

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-072	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2021
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NAME OF PROVIDER OR SUPPLIER I INNOVATIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 317 WEST MAIN STREET SANFORD, NC 27330
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on May 28, 2021. The complaint was unsubstantiated (Intake #NC00176850). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .1200 Psychosocial Rehabilitation Facilities for Individuals with Severe and Persistent Mental Illness. 10A NCAC 27G. 5400 Day Activity for Individuals of All Disability Groups.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____