

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>MHL098-145</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>07/01/2021</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GETTING READY INC</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>510 CHURCH STREET</b><br><b>BLACK CREEK, NC 27813</b> |
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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 |
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| V 000              | <p><b>INITIAL COMMENTS</b></p> <p>An annual, complaint and follow up was completed on July 1, 2021. The complaint was unsubstantiated (Intake #NC00178555). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G. 1400 Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances and 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program.</p> | V 000         |   |                    |

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| Division of Health Service Regulation<br>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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