

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL096-255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/15/2021
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NAME OF PROVIDER OR SUPPLIER MAIN ST UNIVERSAL GROUP HOME 1	STREET ADDRESS, CITY, STATE, ZIP CODE 904 NATIONAL DRIVE GOLDSBORO, NC 27534
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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 limited follow up survey for the Type A1 rule violation was completed on 7/15/21. This was a limited follow up survey, only 10A NCAC 27D .0304 Protection From Harm, Abuse, neglect or Exploitation (V512) and 10A NCAC 27F .0105 Client's Personal Funds (V542) were reviewed for compliance.</p> <p>The following were brought back into compliance: 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) and 10A NCAC 27F. 0105 Client's Personal Funds (V542). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p>	V 000		

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