Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-007	A. BUILDING: ______ B. WING ______	R 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FLYNN FELLOWSHIP HOME OF GASTONIA, INC	311 SOUTH MARIETTA STREET GASTONIA, NC 28052

(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	INITIAL COMMENTS A limited follow up survey for the Type A2 rule violation was completed on 10/26/21. This was a limited follow up survey, only 10A NCAC 27G .0209 Medication Requirments (V116, V117 crossed referenced to V118) was reviewed for compliance. The following was brought back into compliance: 10A NCAC 27G .0209 Medication Requirments (V116, V117, cross referenced to V118). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600E Supervised Living for Adults with Substance Abuse Dependency.	V 000		

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