PRINTED: 11/22/2021 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL041-773	B. WING		11/17/2021	
NAME OF D	DOVIDED OD SUDDI IED		DDESS CITY STA	TE ZID CODE	•	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1921 NEW GARDEN ROAD K107						
SERVANT'S HEART GREENSBORO, NC 27410						
(V4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION					
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	TIVE ACTION SHOULD BE COMPLETE CED TO THE APPROPRIATE DATE	
V 000	00 INITIAL COMMENTS		V 000			
	An annual survey was deficiencies were cite	s completed on 11/17/21. No d.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE