STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-328	A. BUILDING: _____ B. WING _____	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRATIONZ LEVEL II	5089 BAUX MOUNTAIN ROAD WINSTON SALEM, NC 27105

(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 An annual survey was attempted on 12/8/21. According to the Licensee there are no clients receiving services at the facility. The last time clients resided at the facility was 6/19/21. Attempted survey on 10/12/21 the last client record dated 6/19/21 was reviewed. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment Facility for Children & Adolescents Interview on 12/8/21 with the Director revealed: - Referrals have been coming in. However the referrals are not appropropriate for Level II care.	V 000		