STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-342	A. BUILDING: _____ B. WING _____	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOTTOM UP OUTREACH CENTER	554 BEDFORD KNOLL DRIVE WINSTON SALEM, NC 27107

(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 complaint survey was completed on December 8, 2021. The complaints were substantiated (Intake #NC00183230 and #NC00183240). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600 Supervised Living for Adults with Developmental Disabilities. The survey sample consisted of audits of 3 current clients, 0 former clients, 0 deceased clients.	V 000		