

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/30/2021
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NAME OF PROVIDER OR SUPPLIER SCI - MORGANTON RESPITE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 BETHEL ROAD MORGANTON, NC 28680
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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>An annual survey was attempted on 11/30/21. According to the Administrator there are no clients being served at the facility. The last time clients were served at the facility was 8/30/21.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services for Individuals of All Disability Groups.</p> <p>Interview on 11/30/21 with the Administrator revealed: -they have had very few clients due to COVID-19 pandemic -respite stays are generally 7-10 days -the last client served was from 8/23/21-8/30/21.</p> <p>Review on 11/30/21 of Former Client #1's record revealed: -admission date of 8/23/21 -diagnoses of Bipolar Disorder (d/o), Moderate Hypoxic Ischemic Encephalopathy, Falls, Autistic, Intellectual Developmental Disability, Severe Insomnia, Generalized Anxiety d/o -discharge date of 8/30/21.</p>	V 000		

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