

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL049-157	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/19/2022
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NAME OF PROVIDER OR SUPPLIER BLUE HORIZONS	STREET ADDRESS, CITY, STATE, ZIP CODE 130 SAINT JILL CIRCLE STATESVILLE, NC 28625
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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>A follow-up survey for the Type A1 was completed on 1/19/22. This was a follow-up survey, only 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals(V110) was reviewed for compliance. The following was brought back into compliance: 10A NCAC 27G Competencies and Supervision of Paraprofessionals (V110) .</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>The survey sample size consisted of audits of 4 of 4 current clients.</p>	V 000		

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