

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL013-158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/17/2022
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NAME OF PROVIDER OR SUPPLIER CABARRUS VOCATIONAL OPPORTUNITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 107 COMMERCIAL PARK DRIVE CONCORD, NC 28027
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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, complaint and follow-up survey was completed on 2/17/22. The complaint was unsubstantiated(Intake #183521). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .2300 Adult Developmental Vocational Programs for Individuals with Developmental Disabilities and 10A NCAC 27G .5400 Day Activity for Individuals of all Disability Groups.</p> <p>The survey sample consisted of audits of 5 current clients.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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