

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-865</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/25/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>P H P OF NC INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 B PONY ROAD</b> <b>ZEBULON, NC 27597</b>
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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><b>INITIAL COMMENTS</b></p> <p>An annual, complaint and follow up survey was completed on 4/25/22. The complaints were substantiated (intake #NC00187340 and NC00187342). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories 10A NCAC 27G .2300 Adult Developmental and Vocational Programs for Individuals with Developmental Disabilities and 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups.</p> <p>This facility has a current census of 35. The survey sample consisted of audits of 4 current clients.</p>	V 000		

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