

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-881</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/21/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ABLECARE DAY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>305 WESTGATE DR STE A GREENSBORO, NC 27407</b>
--	--

(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>A complaint survey was completed on 6/21/2022. The complaint was unsubstantiated (intake #NC190181). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .2300 Adult Developmental and Vocational Programs for Individuals with Developmental Disabilities.</p> <p>This facility is licensed for 0 and has a census of 11.</p>	V 000		

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