Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411182	A. BUILDING: _____ B. WING _____	07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A S A P	5016 WEST FRIENDLY AVENUE GREENSBORO, NC 27410

(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	INITIAL COMMENTS An annual survey was attempted on 7/12/22. According to the Performance Improvement Coordinator there are no clients being served at the faciity. The last time clients were served at the facility was 6/8/22. The facility is licensed for the following service category: 10A NCAC 27G. 5600D Supervised Living for Minors with Substance Abuse Dependency. Interview on 7/12/22 with the Performance Improvement Coordinator revealed: - There are no clients currently being served at the facility with the last client being discharged from the facility on 6/8/22 - The facility closed as of 6/30/22; however, notification had not been made to the Division of Health Service Regulation as of today's date.	V 000		

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