

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-619	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/17/2022
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NAME OF PROVIDER OR SUPPLIER LEARNING SERVICES-RIVER RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 5301 ROBBINS DRIVE RALEIGH, NC 27610
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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 complaint survey was completed on 5/17/22. The complaint was unsubstantiated Intake #NC00187861. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .2100 Specialized Community Residential Centers for Individuals with Developmental Disabilities</p> <p>The survey sample consisted of an audit of 1 current client.</p>	V 000		

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