

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-582	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/02/2022
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NAME OF PROVIDER OR SUPPLIER Varsity Crest #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1503 CREST ROAD APT. 103 RALEIGH, NC 27606
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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
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V 000	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on 11/2/22. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p> <p>This facility is licensed for two and has a current census of one. The survey sample consisted of audits of one current client.</p>	V 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____