

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL039-059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/07/2022
NAME OF PROVIDER OR SUPPLIER LEARNING SERVICES CORP-TRANSITIONAL I			STREET ADDRESS, CITY, STATE, ZIP CODE 796 RECOVERY ROAD CREEDMOOR, NC 27522		
(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>An annual survey was completed on 11/7/22. 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>This facility has a current census of 10. The survey sample consisted of audits of 3 current clients.</p>	V 000			

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE