PRINTED: 11/09/2022 FORM APPROVED

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	
			A. BUILDING:			ь	
MHL040-019		MHL040-019	B. WING		 	R 10/21/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
EASTER SEALS UCP-GREENE COUNTY GROUP HON 704 SE SECOND STREET SNOW HILL, NC 28580							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE		
V 000	V 000 INITIAL COMMENTS						
	A complaint and follow up survey was completed on October 21, 2022. The complaint was unsubstantiated (Intake #NC00193209). No deficiencies were cited.						
	category: 10A NCAC	ed for the following service C 27G .5600C Supervised Developmental Disabilities.					
		ed for 6 and currently has a rvey sample consisted of ients.					

Division of Health Service Regulation

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

TITLE (X6) DATE