

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0411032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2023
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NAME OF PROVIDER OR SUPPLIER MOSE KISER JR LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 5146 DUNSTAN ROAD GREENSBORO, NC 27405
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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>An annual survey was completed on 2/24/23. No deficiencies were cited.</p> <p>The facility is licensed for the following service categories: 10A NCAC 27G .3100 Non-hospital Medical Detoxification - Individuals who are Substance Abusers and 10A NCAC 27G .3400 Residential Treatment - Individuals with Substance Abuse Disorders.</p> <p>The facility is licensed for 24 and currently has a census of 13. The survey sample consisted of audits of 3 current clients.</p>	V 000		

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