

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL026-171</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/17/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CREST, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>241 TILLINGHAST STREET</b> <b>FAYETTEVILLE, NC 28301</b>
---	---

(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><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on March 17, 2023. The complaints were unsubstantiated (intakes #NC00199150 and #NC00197219). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .2300 Adult Developmental Vocational Program for Individuals with Developmental Disabilities.</p> <p>This facility has a current census of 40. 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 \_\_\_\_\_