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 |
|---|---|---|---|
| | MHL034-342 | A. BUILDING: _____ B. WING _____ | R-C 05/25/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOTTOM UP OUTREACH CENTER | 554 BEDFORD KNOLL DRIVE WINSTON SALEM, NC 27107 |

| (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 | INITIAL COMMENTS<br><br>A follow up and complaint survey was completed on 5/25/23. The complaint (intake #NC00201748) was unsubstantiated. No deficiencies were cited.<br><br>This facility is licensed for following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.<br><br>The facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 3 current clients. | V 000 | | |

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