

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL038-024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/15/2023
NAME OF PROVIDER OR SUPPLIER THE PASSAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 532 MOOSE BRANCH ROAD ROBBINSVILLE, NC 28771		
(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 and follow up survey was attempted on 6/15/23. No clients are currently residing at the facility.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults With Mental Illness.</p> <p>The facility is licensed for 6 and currently has no clients. No clients have been served since April 2022 according to the Director of IDD Services.</p>	V 000		

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

TITLE

(X6) DATE