

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-282</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/22/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA PSR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>910 ROBERTS DRIVE GASTONIA, NC 28054</b>
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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><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on 09/22/2023. The complaint was unsubstantiated (intake #NC00206111). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1200 Psychosocial Rehabilitation Facilities for Individuals with Severe and Persistent Mental Illness.</p> <p>This facility has a current census of 38. The survey sample consisted of audits of 2 former clients.</p>	V 000		

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