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
	MHL097-045	A. BUILDING: _____ B. WING _____	R-C 11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY HILLS GROUP HOME	179 HOLLY BROOK STREET NORTH WILKESBORO, NC 28659

(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 A follow up survey was completed on 11/7/23. No deficiencies were cited. The facility is licensee for the following service category: 10A NCAC 27G .5600 C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 beds and currently has a census of 6. 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