

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-130	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2023
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NAME OF PROVIDER OR SUPPLIER PEACE IN THE CITY-GRACE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 328 MOUNTAIN VIEW STREET FOREST CITY, NC 28043
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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>INITIAL COMMENTS</p> <p>A annual survey was attempted on 11/14/23. According to the Licensee there were no clients being served at the facility. The last time clients were served at the facility was 6/21/22.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment Facilities for Children or Adolescents.</p> <p>Interview on 11/14/23 with the Licensee revealed: -Clients had not been served at the facility since 6/21/22 due to a staff shortage. -Unsure when would be able to begin accepting clients, however intentions were to renew the license for 2024.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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