

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-111	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/22/2024
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NAME OF PROVIDER OR SUPPLIER THE ALLIANCE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 503 DABNEY DRIVE HENDERSON, NC 27536
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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 complaint survey was completed on February 22, 2024. The complaint was unsubstantiated (Intake #NC00212160). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .2300 Adult Developmental and Vocational Programs for Individuals with Developmental Disabilities & 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups.</p> <p>This facility has a current census of 25. The survey sample consisted of audits of 4 current clients.</p>	V 000		

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