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
	MHL092-581	A. BUILDING: _____ B. WING _____	R 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VARSITY CREST #2	**1503 CREST DRIVE, APT #102 RALEIGH, NC 27606**

(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 limited follow up survey for the Type A1 was completed on 2/29/24. This was a limited follow up survey, only 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V107) was reviewed for compliance. The following was brought back into compliance 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V107). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for two and has a current census of two. The survey sample consisted of audits of two current clients.	V 000		

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