

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-983</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/27/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIVING WITH AUTISM DAY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4325 TRYON ROAD</b> <b>RALEIGH, NC 27606</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 March 27, 2024. The complaints were substantiated intake #NC00212342 &amp; #NC00212892. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups.</p> <p>This facility has a current census of 53. The survey sample consisted of audits of 2 current clients.</p>	V 000		

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