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
	MHL034-374	A. BUILDING: ______ B. WING ______	R 04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DISABILITY MANAGEMENT SERVICES	**3365 NEW WALKERTOWN ROAD WINSTON SALEM, NC 27105**

(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 was attempted on April 12, 2024. According to the Owner/Licensee/Qualified Professional (O/L/QP)'s wife, the O/L/QP was hospitalized and there are no clients being served at the facility. The last time clients were served at the facility was on January 22, 2024. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. Interviews on April 15, 2024 and April 22, 2024 with the O/L/QP revealed he continued to be hospitalized with a discharge plan of returning to a rehabilitation facility. The record of the last client served was not available to be reviewed. He stated he still planned to sell his facility.	V 000		

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