

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-171	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/17/2024
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NAME OF PROVIDER OR SUPPLIER CREST, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 241 TILLINGHAST STREET FAYETTEVILLE, NC 28301
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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 April 17, 2024. The complaint was unsubstantiated (intake #NC00215475). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .2300 Adult Developmental Vocational Programs for Individuals with Developmental Disability.</p> <p>This facility has a current census of 33. The survey sample consisted of audits of 3 current clients.</p>	V 000		

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