

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-374	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2024
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NAME OF PROVIDER OR SUPPLIER DISABILITY MANAGEMENT SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3365 NEW WALKERTOWN ROAD WINSTON SALEM, NC 27105
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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 limited follow up survey was attempted on May 20, 2024. According to the Licensee, there are no clients being served at the facility. The last time clients were served at the facility was January 22, 2024.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>Interview on 5/21/24 with the Licensee/Owner/Qualified Professional revealed he had a continued plan to sell his group home business. He would contact surveyor when the record of the last client served was ready to be reviewed. He was not interested in turning in his facility license at this time.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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