

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL049-157 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 06/18/2024 |
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| NAME OF PROVIDER OR SUPPLIER BLUE HORIZONS | STREET ADDRESS, CITY, STATE, ZIP CODE 130 SAINT JILL CIRCLE STATESVILLE, NC 28625 |
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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 |
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| V 000 | <p>INITIAL COMMENTS</p> <p>An annual and follow-up survey was completed on 6/18/24. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.</p> | V 000 | | |

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