

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
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NAME OF PROVIDER OR SUPPLIER BEYOND CHALLENGES COMMUNITY SERVICE	STREET ADDRESS, CITY, STATE, ZIP CODE 312 CHESTNUT STREET HENDERSON, NC 27536
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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 7/23/24. The complaint was unsubstantiated (Intake # 00219390). No deficiencies were cited.</p> <p>The facility is licensed for the following service category 27G. 5400 Day Activity for Individuals of all Disability Groups.</p> <p>The facility has a current census of 36. The survey sample consisted of audits of one current client.</p>	V 000		

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