	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED 08/13/2024	
		mhl041-818	B. WING			
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
UCCESS	FUL TRANSITIONS, LLC	C RESIDENTIAL CAF	NDON DRIVE DINT, NC 27262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
V 000	INITIAL COMMENTS		V 000			
	A complaint and follor on August 13, 2024. <sup>-</sup> unsubstantiated (inta Deficiencies were cite	ke #NC00219762).				
		d for the following service 27G .1700 Residential re for Children or				
		d for 4 and has a current vey sample consisted of ents.				
V 111	27G .0205 (A-B) Assessment/Treatme	nt/Habilitation Plan	V 111			
	PLAN	ITATION OR SERVICE				
	client, according to go the delivery of service be limited to: (1) the client's prese					
	established diagnosis of admission, except detoxification or other shall have an establis	admitting diagnosis with an s determined within 30 days that a client admitted to a r 24-hour medical program				
	and	l, family, and medical history; ssessments, such as				
	psychiatric, substance vocational, as approp	e abuse, medical, and priate to the client's needs. re provided prior to the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		mhl041-818			08	/13/2024
NAME OF PF	ROVIDER OR SUPPLIER			ZIP CODE		
SUCCESS	FUL TRANSITIONS, LL	C RESIDENTIAL CAF	NDON DRIVE DINT, NC 27262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 111	Continued From pag	e 1	V 111			
	referred to as the "pla	or service plan, hereafter an," strategies to address the oblem shall be documented.				
	facility failed to comp	iews and interviews, the ete an assessment prior to es for 1 of 3 audited clients				
	Review on 8/7/24 of -An admission date of	client #1's record revealed: of 5/29/24				
	Oppositional Defiant	ive Attachment Disorder, Disorder, Attention Deficit er, Fetal Alcohol Syndrome				
	-An "external" admise 3/27/24 noted "has h	sion assessment dated ad a increase in risk taking to wander all day, has been				
	found in the crawl sp have been days whe	aces of his neighbors, there re his whereabouts were time it was discovered he				
	had broken into the s gym, he was stealing	school and was staying in the g food from gas stations, laptop, has a history of				
	making false allegation					
	been beaten, not bei	ng fed, that he was put out of chool at this time, has				

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		mhl041-818	B. WING		30	8/13/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
SUCCESS	FUL TRANSITIONS, LL	C RESIDENTIAL CAF	NDON DRIVE DINT, NC 27262			
(X4) ID		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN ( (EACH CORRECTIVE A		(X5) COMPLET
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	DATE
V 111	Continued From pag	e 2	V 111			
	kevs from school. is	not allowed to be home				
	-	ad to take him to work with				
		the car, mom was at risk of				
		ause of his behaviors in the				
	-	navioral control, was putting				
	• •	where he can be harmed due				
	to his wandering beh	aviors, needs to be in a				
	place where he can i	receive mental health				
	treatment, and where	e he will be safe while				
	receiving services, n	eeds to work to verbalize and				
	express his emotions	s while learning positive				
		y refraining from leaving the				
		sion or without known				
	-	ing his trauma in treatment,				
		ies during an increase in				
		ectively communicate				
		s with others, learn to exhibit				
		all settings by thinking before				
		npulsive decisions, listening				
		is said by authority before				
		effective strategies to calm				
		gitated to prevent property				
		ecting authority figures."				
	-A Comprehensive C	ed 6/9/24 by the Licensed				
	· · · · ·	Reason for Addendum at				
	this time: Client is be					
		services, presenting				
		f addendum: [Client #1] has				
		/e behaviors in recent				
		n having incidents of stealing				
		me. Family has reported that				
		of hiding out in crawl spaces				
		ne. He is currently on long				
		n school due to stealing the				
	-	t #1] also has a history of				
		ons against his caregivers.				
		o admit his past behaviors.				
		lay some manipulative and				
		Meets Eligibility Criteria for				

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		mhl041-818	B. WING			
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,		08	/13/2024
	FUL TRANSITIONS, LLC	1458 LO	NDON DRIVE			
000200		HIGH PC	DINT, NC 27262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
V 111	Continued From page	e 3	V 111			
	Level III Residential Therapy." -No documentation of an initial assessment prior to the delivery of services. Interview on 8/7/24 with the Qualified Professional revealed: -Client #1 was an emergency placement into the facility on 5/29/24 -"He was an emergency placement from DSS (Department of Social Services) until they can find him placement." -"I did not do an initial assessment as he was an					
	emergency placemer	nt. I just went with what DSS e future, I will complete an				
	Interview on 8/8/24 w Professional revealed -Remembered meetin placed at the facility					
	-"I wrote up an asses was prior to him rece	sment, but I don't think it iving services. I don't know ssment on the Addendum				
	-"When he (client #1) emergency placementransitioning to a full-	time client. And DSS agreed Ild get services for him."				
	placement of clients t	that the initial assessment to the delivery of services.				
V 289	27G .5601 Supervise	d Living - Scope	V 289			
		1 SCOPE is a 24-hour facility which ervices to individuals in a				

STATE FORM

8LJI11

If continuation sheet 4 of 13

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTR A. BUILDING:		(X3) DATE SUF COMPLET	
		mhl041-818	B. WING		08/13/	2024
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP C		00/13/	2024
		1458 LO	NDON DRIVE			
BUCCESS	FUL TRANSITIONS, LLC	RESIDENTIAL CAF	DINT, NC 27262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
V 289	Continued From page	e 4	V 289			
	these services is the rehabilitation of indivi illness, a developmen or a substance abuse supervision when in t (b) A supervised livin the facility serves eith (1) one or more (2) two or more (2) two or more (2) two or more (2) two or more illnes and adult client same facility. (c) Each supervised licensed to serve a sp designated below: (1) "A" designal serves adults whose illness but may also h (2) "B" designal serves minors whose developmental disabil diagnoses; (3) "C" designal serves adults whose developmental disabil diagnoses; (4) "D" designal serves minors whose substance abuse dep other diagnoses; or	duals who have a mental ntal disability or disabilities, e disorder, and who require he residence. ng facility shall be licensed if her: e minor clients; or e adult clients. ts shall not reside in the living facility shall be pecific population as tion means a facility which primary diagnosis is mental have other diagnoses; tion means a facility which primary diagnosis is a lity but may also have other ation means a facility which primary diagnosis is a lity but may also have other ation means a facility which primary diagnosis is a lity but may also have other ation means a facility which primary diagnosis is a lity but may also have other ation means a facility which primary diagnosis is bendency but may also have tion means a facility which				
	three adult clients wh mental illness but ma	ich serves no more than ose primary diagnoses is y also have other dult clients or three minor				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		mhi041-818	B. WING		00/40/0004	
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		00	/13/2024
	FUL TRANSITIONS, LL	1458 I O	NDON DRIVE	, 0022		
DUCCESS	FUL TRANSITIONS, LL	HIGH PC	DINT, NC 27262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 289	Continued From page	e 5	V 289			
	<ul> <li>V 289 Continued From page 5</li> <li>clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&amp;(B); (6); (7)</li> <li>(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16);</li> <li>(18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)</li> <li>(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205</li> <li>(a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)</li> <li>(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304</li> <li>(b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).</li> </ul>					
	interviews, the facility scope of the program waiver for 1 of 4 clien after the fiscal year. Observation on 8/7/2 license revealed: -The facility was licen Attempted review on	ns, record reviews and / failed to operate within the n and failed to request a nts (#3) after turning 18 or				
	revealed: -No request for a wai requirements.	iver related to licensure				
	Review on 8/7/24 of -An admission date of alth Service Regulation	client #3's record revealed: of 9/3/21				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		mhl041-818	B. WING		08	8/13/2024
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
UCCESS	FUL TRANSITIONS, LLC	C RESIDENTIAL CAF	NDON DRIVE DINT, NC 27262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 289	Continued From page	e 6	V 289			
	Disorder, Oppositiona	on Deficit Hyperactivity al Defiant order, Conduct Disorder and				
	Review on 8/9/24 of client #3's Priority Enrollment from the Job Corps, dated 7/9/24 and sent to the Qualified Professional (QP) revealed: -"As it stands, we're waiting on medical records for this applicant, but expect that we will be submitting it to the region."					
	-Was 18 years old -Would turn 19 years -"I have aged out of t guardian before I turr her wouldn't have an going into the Job Co (September 2024)	l Diploma) and learn skills in				
	-Was aware client #3 19 next month -Had worked for mon Job Corps -Was aware client #3 for six months after h of the fiscal year (Jur -Was not aware she waiver for client #3 to left for Job Corps -"[The Licensee] state stay with him (at his p	could have requested a p remain in the facility until he ed he would have [client #3] personal residence) if [client				
	#3] is not accepted in Interview on 8/13/24					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		mhl041-818	B. WING		08	/13/2024
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
UCCESS	FUL TRANSITIONS, LL	C RESIDENTIAL CAF	NDON DRIVE DINT, NC 27262			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 289	Continued From pag	je 7	V 289			
	wants to put him out navigating his plan of when he was 17. He and then dad started successful with the 0 he wanted to go into switched up and said [The QP] has been w are working with his placement. We are w	to him (client #3). No one on the street. We have been once he turned 18. We started was hospitalized for a while d having contact. He was not GED classes. Then he stated the military. Then he d he wanted to try Job Corp. working hard with them. We LME until we find transitional waiting for the LME to He has no skills to speak of."				
V 297	27G .1705 Resident P	ial Tx. Child/Adol - Req. for L	V 297			
	provided in each fac week by a licensed p this Rule, licensed p individual who holds license issued by the a human service pro Carolina. For substa shall include a licens Specialist or a certifi (b) The consultation this Rule shall includ (1) clinical sup professional specifie Section; (2) individual, services; or (3) involvement	SSIONALS ical consultation shall be ility at least four hours a professional. For purposes of rofessional means an a license or provisional e governing board regulating fession in the State of North ance-related disorders this sed Clinical Addiction ed Clinical Supervisor. a specified in Paragraph (a) of				

STATE FORM

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If continuation sheet 8 of 13

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		mhl041-818	B. WING		08	8/13/2024
AME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
UCCESS	FUL TRANSITIONS, LL	C RESIDENTIAL CAF	NDON DRIVE			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN (	OF CORRECTION	(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	D THE APPROPRIATE	COMPLE DATE
V 297	Continued From pag	e 8	V 297			
	This Rule is not met	-				
		iews and interviews, the re face to face clinical				
	•	vided in the facility at least				
	-	a Licensed Professional				
	(LP). The findings a	re:				
	Review on 8/9/24 of	the LP's record revealed:				
	-A hire date of 4/29/0	)9				
	-A job description of	LP				
	Review on 8/9/24 the	e facility's Contract				
		ed emails from the Licensee				
	-	ent Entity/Managed Care				
	Organization (LME/N	May Concern: Subject: LP, 1				
		saying that [LP] has been an				
		esidential level 3 program for				
		y years and has done an				
		ing with our clients. I				
		been offered a position with e is a concern about conflict				
		a conflict of interest we have				
		ervices with [LME/MCO].				
	Please see attached	provider change form sent				
		nt. This should allow [LP] to				
	continue providing se					
		_icensee to the LME/MCO about me ending my contact				
	•	to a conflict of interest with				
		not received the forms we				
	talked about needed	to end the contract. As this				
		atter, please send me the				
	forms"					
		LME/MCO to the Licensee. I ermination of your contract,				
	-	the required documents that				

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		B. WING			
NAME OF PROVIDER OR SUPPLIE	mhl041-818	ADDRESS, CITY, STATE,		08	8/13/2024
	1458 LC	ONDON DRIVE			
SUCCESSFUL TRANSITIONS	S. LLC RESIDENTIAL CAF	OINT, NC 27262			
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 297 Continued From	page 9	V 297			
are needed from process" -"8/8/24From was following up contract cancella completedmy get clearance to you help me faci be a big helpv worked with ove make sure they Interview on 8/8, Professional (LF -Had a death in an issue with he -"[The Licensee] [LME/MCO]s an interest. We are paperwork to co terminated his co [LME/MCO]. He [the LME/MCO]. He [the LME/MCO]. He [the LME/MCO]. He [the rapy to the cl QP] is providing least three week Interview on 8/7, Professional rev -"[The LP] had a having some con clear up. [The LF LME/MCO]. We [LME/MCO]. The approximately th has an ad out fo will be back next	a the provider to complete that the Licensee to the LME/MCO. I with you to determine if the ation process has been employee [LP] has been trying to continue working with uscan ilitate that clearance as this will we have clients that she has r six months, and we are trying to have continuity of services" /24 with the Licensed P) revealed: the family recently and there was r contract. had a contract with one of the d it was considered a conflict of currently working on the rrect that. [The Licensee] has ontract with that particular does not have any clients from I have not provided individual ients in quite some time. [The group sessions. It has been at as since I have provided services."				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		mhl041-818	B. WING		30	8/13/2024
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
UCCESS	FUL TRANSITIONS, LL	C RESIDENTIAL CAF	NDON DRIVE DINT, NC 27262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 297	Continued From pag	le 10	V 297			
	has been out."					
	-"[The LP] a while ba position with the LMI interest. We have no LME/MCO. The proo the contact. We are Relations and the Le for the paperwork be she is a stickler for the would not allow an e determination within back. If it does not w	with the Licensee revealed: ack thought that should take a E/MCO. That was a conflict of ot ever had any clients from cess is completed to cancel now working with Network egal Team. [The LP] is waiting offore she comes back out as the rules. They (LME/MCO) exception. I hope to get a the week. I do have a fall work out with [the LP], I have farms out therapists to				
V 736	27G .0303(c) Facility	/ and Grounds Maintenance	V 736			
		REMENTS				
		ns and interviews, the facility e not maintained in a safe				
	of the facility and its -The flooring (2 feet office, under the Qua	/24 from 9:03am to 3:42pm grounds revealed: by 18 inches) in the staff's alified Professional's desk od and had deep grooves in				
	-Outside client #1's t	pedroom door was writing on rosty the Snowman."				

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		mhl041-818	B. WING		00	3/13/2024
					00	0/13/2024
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, NDON DRIVE	ZIP CODE		
UCCESS	FUL TRANSITIONS, LLC	C RESIDENTIAL CAF	DINT, NC 27262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
V 736	Continued From page	e 11	V 736			
	hole approximately 3 diameter -Client #1's bedroom window, had a 8 inch -Client #3's dresser v -One of the kitchen's -The wooden plank s had exposed cardboa Interview on 8/7/24 w -"I was mad, and I pu Interviews on 8/7/24 w -"I was mad, and I pu Interviews on 8/7/24 w Professional (QP) rev -"[Client #1] got into t that did not belong to guardian, he got mad	a by 8 inch hole in it. was missing a drawer drawers was missing step to the recreation room ard with client #1 revealed: ut holes in the walls." with clients #2, #3 and #4 and punched several holes in				
	-The Licensee had pa and was waiting for it them. Interview on 8/7/24 w -"I am in the process the facility)our next about redoing the floo additional room (whe	8/7/24 with the QP revealed: atched the holes in the walls t to dry before he painted with the Licensee revealed: of making them (repairs to step is to talk to someone ors and rebuilding the ere the step down to the den o call Construction and				
	This deficiency const and must be correcte	titutes a re-cited deficiency ad within 30 days.				

AND PLAN OF CORRECTION IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING ADDRESS, CITY, STATE, ZIP CODE		(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
					00/10/000		
	COF PROVIDER OR SUPPLIER STREET.				30	08/13/2024	
		1458   0	NDON DRIVE	ZIF CODE			
UCCESS	FUL TRANSITIONS, LL	C RESIDENTIAL CAF HIGH PC	DINT, NC 27262				
(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) COMPLET DATE	