Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL045-127	A. BUILDING: ______ B. WING ______	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EQUINOX RTC	**41 HERO'S WAY** **HENDERSONVILLE, NC 28792**

(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	INITIAL COMMENTS An annual survey was attempted on September 11, 2024. According to the Executive Director, there are no clients being served at the facility. The last time clients were served at the facility was October 2023. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. Interview on 9-11-24 with the Executive Director revealed: -Clients had not been served at the facility since October 2023. -Was in the process of a Change of Ownership. -Had been working with Division of Health Service Regulation Licensure and Construction divisions on the licensure change. -Was aware of the time sensitive nature of a licensure change due to clients not having been served at the facility.	V 000		

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