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
	MHL014-087	A. BUILDING: _____ B. WING _____	R 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDING	2419 MORGANTON BOULEVARD LENOIR, NC 28645

(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 and follow up survey was attempted on 9/6/24. According to the Director/Licensee there are no clients being served at the facility. The last time client were served at the facility was 4/19/24. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staf Secure for Children or Adolescents. This facility is licensed for 4 and currently has no clients. Interview on 9/6/24 with the Director/Licensee the last client served was discharged on 4/19/24. The facility will remain closed with no decision to re-open.	V 000		

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