

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/02/2024
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NAME OF PROVIDER OR SUPPLIER KRYSTAL'S HOUSE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 83 WHITE HORSE RD PIKEVILLE, NC 27863
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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 attempted on October 2, 2024. According to the Licensee there are no clients being served at the facility. The last time clients were served at the facility was April 2022.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p> <p>Interview on 10/2/24 the Licensee stated: -The facility last served clients in 2022. -She closed the facility April 1, 2022. -She was in the process of completing a Change of Ownership to her brother. -The Change of Ownership process had started.</p>	V 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____