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
	MHL023-233	A. BUILDING: _____ B. WING _____	R 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTNEY BLENDS	539 APRIL DRIVE SHELBY, NC 28152

(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 A limited follow up survey for the Type A1 was completed 10/29/24. This was limited follow up survey , only 10A NCAC 27G .0209 Medication Requirements (V118) , 10A NCAC 27G .0209 Medication Requirements (V116) , 10A NCAC 27G .0209 Medication Requirements (V117), 10A NCAC 27G .0209 Medication Requirements (V119) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0209 Medication Requirements (V118) , 10A NCAC 27G .0209 Medication Requirements (V116) , 10A NCAC 27G .0209 Medication Requirements (V117), 10A NCAC 27G .0209 Medication Requirements (V119). No deficifiences were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 3 and has a current census of 2. The survey sample consisted of an audit of 2 current clients.	V 000		

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