

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/29/2024
NAME OF PROVIDER OR SUPPLIER GOD'S SPECIAL PEOPLE		STREET ADDRESS, CITY, STATE, ZIP CODE 17 SWANN HILL LANE ASHEVILLE, NC 28805		
(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	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on October 29, 2024. The complaint was unsubstantiated (NC#00222217). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>The survey sample consisted of an audit of 1 deceased client.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE