| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL047-168 | A. BUILDING: _____ B. WING _____ | 12/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SISTERLY LOVE | 170 CLUB POND ROAD RAEFORD, NC 28376 |

| (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<br><br>An annual survey was attempted on December 17, 2024. The Licensee and/or a representative were not available and therefore the survey was not conducted. According to the Licensee there are clients being served at the facility.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.<br><br>A message, via telephone and text, were left on the Licensee's voicemail and through text on 12/17/24. A message was left, via telephone, on the Residential Technician's voicemail on 12/17/24. The Residential Technician contacted the surveyor on 1/19/24 and inquired about the surveyor's message and stated that she'd inform the Licensee. The Licensee contacted the surveyor on 1/19/2024 and reported that she had not received the surveyor's message and that the Residential Technician informed her that the surveyor had attempted to make contact. The Licensee reported that the clients and staff were unavailable on 12/17/24 and that clients were being served at the facility. | V 000 | | |