

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER SCI - MORGANTON RESPITE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 806 BETHEL ROAD MORGANTON, NC 28680		
(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>An annual survey was attempted on January 14, 2025. According to the Licensee there are no clients being served at the facility. The last time clients were served at the facility was December 31, 2024.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services for Individuals of all Disability Groups.</p> <p>Interview on 1-14-25 with the Licensee revealed: -Facility census tended to decrease during the holiday season. -Clients would probably be admitted to the facility within the next week or two.</p> <p>Review on 1-14-25 of Former Client #1's record revealed: -Date of Admission: 10-28-24. -Diagnoses: Moderate Intellectual Disabilities; Generalized Anxiety Disorder; Legal Blindness. -Date of Discharge: 12-31-24.</p>	V 000		

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

TITLE

(X6) DATE