

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029-027 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/24/2025 |
| NAME OF PROVIDER OR SUPPLIER DAVIDSON #2 | | STREET ADDRESS, CITY, STATE, ZIP CODE 434 SHANNON DRIVE LEXINGTON, NC 27292 | | |
| (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 completed on January 24, 2025. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 3 current clients.</p> | V 000 | | |

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

TITLE

(X6) DATE