

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL013-250</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/26/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>TIMBERT HAVEN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>921 ANCHOR WAY NE</b> <b>KANNAPOLIS, NC 28083</b>		
(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><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on February 26, 2025. The complaint was unsubstantiated (intake #NC00227468). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents.</p> <p>This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 1 current clients.</p>	V 000			

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

TITLE

(X6) DATE