

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL084-100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/31/2025
NAME OF PROVIDER OR SUPPLIER MOSS LANE II		STREET ADDRESS, CITY, STATE, ZIP CODE 42414 MOSS LANE NEW LONDON, NC 28127		
(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 and limited follow up survey for the Type A1 was completed on 3/31/25. This was a limited follow up survey, only 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) was reviewed for compliance. The following was brought back into compliance: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). The complaint was unsubstantiated (intake #NC00228257). 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 Disability.</p> <p>This facility is licensed for 3 and has a current census of 3. 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