STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-149	A. BUILDING: _____ B. WING _____	C 05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QCS DAY PROGRAM & PSR	310 S CHURCH STREET, SUITE 163 ROCKY MOUNT, NC 27804

(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 A complaint survey was completed on 5/2/25. The complaints were substantiated (Intakes # NC00228718, #NC00229679, #NC00229737). No deficencies were cited. This facility is licensed for the following service catergories: 10A NCAC 27G.1200 Psychosocial Rehabilitation facilities for individuals with severe and persistent mental illness and 10A NCAC 27G.5400 Day Activity for Individuals of all Disability Groups. This facility has a current census of 20. The survey sample consisted of audits of 1 client.	V 000		