

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL090-195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/03/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ANDERSON HEALTH SERVICES-SIMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1915-C HASTY ROAD MARSHVILLE, NC 28103</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 6-3-25. The complaint was unsubstantiated (#NC00230810). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.</p> <p>This facility is licensed for 12 and has a current census of 5. The survey sample consisted of audits of 1 current client.</p>	V 000		

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

TITLE

(X6) DATE