STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-231	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SWING CENTER	7920 RED ROAD ROCKWELL, NC 28138

(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 An annual survey was completed on 9/18/25. No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite for Individuals of All Disability Groups (Day) and 10A NCAC 27G .5100 Community Respite Services for All Disability Groups (Residential). This facility is licensed for 0 day beds and 10 residential beds. The survey sample consisted of audits of 3 current clients.	V 000		