

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL096-249	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2026
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER A CARING HEART INDEPENDENCE CENTER-C	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PARKWAY DRIVE GOLDSBORO, NC 27534
---------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------

(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 survey was completed on February 26, 2026. The complaint was substantiated (intake #NC00235610). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups.</p> <p>This facility has a current census of 14. The survey sample consisted of an audit of 3 current clients.</p>	V 000		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____