

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0411047	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/08/2026
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NAME OF PROVIDER OR SUPPLIER REFIND MY DESIGN	STREET ADDRESS, CITY, STATE, ZIP CODE 1214 GROVE STREET GREENSBORO, NC 27403
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(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 4/8/26. The complaint was unsubstantiated (Intake #NC00236243). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .1200 Psycho-Social Rehabilitation Facility for Individuals with Severe and Persistent Mental Illness and 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups.</p> <p>This facility has a current census of 39. The survey sample consisted of audits of 1 current client.</p>	V 000		

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