

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL018-021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/12/2026
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NAME OF PROVIDER OR SUPPLIER MAIDEN DAY PROGRAM	STREET ADDRESS, CITY, STATE, ZIP CODE 1754 GKN WAY NEWTON, NC 28658
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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 May 12, 2026. The complaint was substantiated (Intake #NC00236797). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .2300 Adult Development and Vocational Programs for Individuals with Developmental Disabilities.</p> <p>This facility is licensed for 0 and has a current census of 68. 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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