

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL079-143	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/07/2026
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NAME OF PROVIDER OR SUPPLIER LAVERNE'S HAVEN-CENTER COURT	STREET ADDRESS, CITY, STATE, ZIP CODE 147 CENTER COURT EDEN, NC 27288
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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 limited follow up survey for the Type A1 was completed on 5/7/26. This was a limited follow up survey, only 10A NCAC 27G .0303 Location and Exterior Requirements were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0303 Location and Exterior Requirements. No deficiencies were cited.</p> <p>This facility is licensed for the following service 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility licensed for 5 and has a current census of 5. 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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