

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL044-053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/01/2026
NAME OF PROVIDER OR SUPPLIER PARK VISTA GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 38 THOMAS PARK DRIVE WAYNESVILLE, NC 28786		
(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 and followup survey was attempted on 7/1/26. According to the Licensee there are no clients being served at the facility. The last client served at the facility was 6/26/26. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. The facility is licensed for 6 and has currently has no clients. An interview on 7/1/26 with the Residential State Director, the last client served was discharged on 6/26/26. The plan was to surrender the license.	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE