

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL023-141</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/16/2025</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SHELBY DAY HABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>950 WENDOVER HEIGHTS DRIVE</b> <b>SHELBY, NC 28150</b>
--	---

(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><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on 12/16/25. The complaints were unsubstantiated (#NC00234785, #NC00235014). 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>The facility is licensed for 0 and has a current census of 25. The survey sample consisted of an audit of 2 clients.</p>	V 000		

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