

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NH0332</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/03/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COVENANT VILLAGE, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 ROBINWOOD ROAD</b> <b>GASTONIA, NC 28054</b>
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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
L 000	<p><b>INITIAL COMMENTS</b></p> <p>A re-licensure and complaint investigation survey was conducted from 11/1/22 through 11/3/22. Event ID# C81M11. The following intake was investigated, NC00193379.</p> <p>Five of the five complaint allegations were not substantiated.</p>	L 000		

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