

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL001-088</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/18/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HUFFINES GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3372 HUFFINES DRIVE</b> <b>BURLINGTON, NC 27217</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
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual, complaint and follow up survey was completed on December 18, 2024. The complaint was unsubstantiated (intake #NC00223846). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for six and has a current census of four. The survey sample consisted of audits of three current clients.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_