PRINTED: 04/30/2018 FORM APPROVED

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                     | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|--|---------------------|---|--|-------------------------------|--|
|  |   |  | B. WING             |   |  |                               |  |
| MHL039-061   |   |  | B. WING             | b. WING   |  | 04/04/2018                    |  |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE |   |  |                     |   |  |                               |  |
| HOUSE OF ANGELS  2187 LAUREN MILL DRIVE OXFORD, NC 27565           |   |  |                     |   |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |  |
| V 000  | 0 INITIAL COMMENTS  |  | V 000               |   |  |                               |  |
|  | An annual survey was completed 4/4/18. No deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living/ Alternative Family Living. |  |                     |   |  |                               |  |
|  | Living/ Alternative Fai   | filly Living.                                      |                     |   |  |                               |  |
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Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE