

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-223	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/03/2019
NAME OF PROVIDER OR SUPPLIER HOME CARE SOLUTIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 187 SCOTLAND RIDGE DRIVE WINSTON SALEM, NC 27107		
(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>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on 10/3/19. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults whose Primary Diagnosis is a Developmental Disability.</p>	V 000			

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

TITLE

(X6) DATE