

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL019-041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 07/29/2020
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NAME OF PROVIDER OR SUPPLIER CAROLINA HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 176 LASSITER HOMESTEAD ROAD DURHAM, NC 27713
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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>INITIAL COMMENTS</p> <p>A complaint and follow-up survey was completed on July 29, 2020. The complaint was unsubstantiated (Intake #NC00167096). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness. 10A NCAC 27G. 1100 Partial Hospitalization For Individuals Who Are Acutely Mentally Ill.</p>	V 000		

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