

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2020
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NAME OF PROVIDER OR SUPPLIER ROSE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 209 ROSE STREET CARY, NC 27511
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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 11/4/20. The Complaints were unsubstantiated (Intake #NC00170601) and substantiated (Intake #NC00168798). 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 Disability.</p>	V 000		

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