

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0411214	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/02/2022
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NAME OF PROVIDER OR SUPPLIER KAREN EZEKIEL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2525 SUFFOLK AVENUE, APARTMENT C GREENSBORO, NC 27265
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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>An annual survey was attempted on 3/2/22. According to the Licensee and the Provider there are no clients being served at the facility. There have been no clients served at the facility since it was licensed on 3/25/21.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternate Family Living.</p> <p>Interview with the Licensee on 3/2/22 revealed the Provider had not served any clients in the facility since it was licensed on 3/25/21.</p> <p>Interview with the Provider on 3/2/22 revealed she had not served any clients in the facility since it was licensed on 3/25/21.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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