STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-272	A. BUILDING: _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF CARE, INC	164 GRAVES STREET BURLINGTON, NC 27217

(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	INITIAL COMMENTS An Annual survey was attempted on August 5, 2022. According to the Administrator there are no clients being served at the facility. The last time clients were served at the facility was over a year ago prior to licensee taking over. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living: Alternative Family Living in a Private Residence. Observation on 8/5/22 at approximately 9:05 am-The group home appeared to be empty. There were no clients and/or staff present. Interview with Administrator revealed that Licensee took over the facility over a year ago and had had some trouble in hiring staff. They initially had clients to serve, but no staff and they now had the staff, but no clients. Licensee was also considering not opening the facility and surrendering the license.	V 000		