STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-107	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD HEALTH CARE 1	706 HUFFMAN MILL ROAD, BUILDING P, APARTMENT 1 BURLINGTON, NC 27215

(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 and follow up survey was attempted on August 11, 2022. According to the Licensee there are no clients being served at the facility. The last time clients were served at the facility was May 15, 2022. The facility is licensed for the following service: 10A NCA 27G .5600C Supervised Living for Adults with Developmental Disability. Observation on 8/11/22 at approximately 9:00 AM revealed: There were no clients or staff present at the facility. Interview on 8/11/22 with the Licensee revealed: He had no clients at that facility. He thought the last time he had a client at that facility was on 5/15/22. He had referrals for that facility, however none of those clients were appropriate. He may be transferring one of his clients from his other facility to that facility.	V 000		