STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-275	A. BUILDING: _____ B. WING _____	R 08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELO'S CARE HOME, INC II	9431 NC HIGHWAY 211 WEST RED SPRINGS, NC 28358

(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 17, 2022. According to the Director there are no clients being served at the facility. The last time clients were served at the facility was December 15, 2021. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. Interview on 8/17/22 the Director stated: -The facility last served clients on 12/15/21. -The clients that were being served at the facility were transferred to a sister facility. -The facility was closed due to a staffing shortage on 12/16/21. -She understood to report when a client is admitted.	V 000		