

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-540</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GLORYLAND HOME CARE SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2617 GROSS AVENUE WAKE FOREST, NC 27587</b>
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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><b>INITIAL COMMENTS</b></p> <p>An annual survey was completed on 6/30/23. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.</p>	V 000		

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