

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/01/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TRIAD HEALTH CARE 1	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on August 1, 2023. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 4 and currently has a census of 1. The survey sample consisted of audits of 1 current client.</p>	V 000		
-------	---	-------	--	--

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