

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL053-082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ANDREWS DRIVE FAMILY CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2621 ANDREWS DRIVE SANFORD, NC 27332</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 February 28, 2024. 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 Disabilities.</p> <p>This facility is licensed for three and currently has a census of one. The survey sample consisted of audits of 1 current client.</p>	V 000		

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