

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FALCON CREST RESIDENTIAL CARE 3 INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3309-A NC HIGHWAY 49 BURLINGTON, NC 27217
--	---

(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 survey was completed on August 30, 2024. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 27G NCAC .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 4 and has a current census of 3. The survey sample consisted of audits of 3 current clients.</p>	V 000		

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