STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-857	A. BUILDING: _____ B. WING _____	R 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST II	1919 BOAZ ROAD RALEIGH, NC 27610

(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 9/5/24. According to the facility Administrator there are no clients being served at the facility. The last time clients were served at the facility was November of 2023. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. Interview on 9/5/24 the facility Administrator reported: - No clients were currently residing at the facility - Last client was served at the facility in November of 2023 - Not sure of the exact date the last client was discharged - Planned to reopen the facility next year - Understood that the license for the facility cannot be renewed if they have not served any clients at the facility in the past year	V 000		