

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL084-105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/15/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>OAKWOOD AFL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 WEST OAKWOOD AVENUE ALBEMARLE, NC 28001</b>		
(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 November 15, 2024. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G. 5600F Supervised Living: Alternative Family Living in a Private Residence.</p> <p>This facility is licensed for 2 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