

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL001-270</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>11/22/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOUSE OF CARE, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2502 BRIARWOOD DRIVE</b> <b>BURLINGTON, NC 27215</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>A follow up survey was completed on November 22, 2024. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>This facility is licensed for 3 and has a current census of 3. The survey sample consisted of 3 clients.</p>	{V 000}			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE