

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL095-049 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | | (X3) DATE SURVEY COMPLETED R 12/04/2024 |
| NAME OF PROVIDER OR SUPPLIER RAY HOUSE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6837 OLD US HIGHWAY 421 DEEP GAP, NC 28618 | | |
| (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 and follow up survey was completed on 12/4/24. 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>The facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.</p> | V 000 | | | |

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

TITLE

(X6) DATE