

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-162	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER ALL GOD'S CHILDREN OF BURLINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 101 RUBY LANE HAW RIVER, NC 27258		
(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 was attempted on April 2, 2025. According to the Director there are no clients being served at the facility. The last time clients were served at the facility was 2/27/24.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>Observation on 4/2/25 at approximately 11:15 am-There were no clients or staff present at the facility.</p> <p>On 4/2/25 the Director stated that she closed the facility on 2/28/24. The last client was discharged on 2/27/24. The landlord contacted her and said she needed to move back into her home. She did not want to go through the trouble of finding another facility for the clients, so she decided to close the facility. She renewed her license for 2025 just in case she decided to get another facility for clients.</p>	V 000		

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

TITLE

(X6) DATE