

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL001-124</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>TRIAD HEALTHCARE SERVICES 2</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>915 SCOTT STREET 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>An annual survey was completed on June 4, 2025. 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>This facility is licensed for 6 and currently has a census of 2.</p> <p>The survey sample consisted of audits of 2 current clients.</p>	V 000		

Division of Health Service Regulation

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

TITLE

(X6) DATE