

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER TRIAD HEALTH CARE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 706 HUFFMAN MILL ROAD, BUILDING P, APARTMENT 14 BURLINGTON, NC 27215		
(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 survey was attempted on June 4, 2025. According to the Licensee there are no clients being served at the facility. The last time clients were served at the facility was February 4, 2025.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G. 5600C. Supervised Living for Adults with Developmental Disabilities.</p> <p>Interview with the Licensee revealed that the facility was not closed. He was submitting a change in service category to add respite services.</p>	V 000		

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

TITLE

(X6) DATE