STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-076	A. BUILDING: _____ B. WING _____	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA HOUSE	7990 NC 751 DURHAM, NC 27713

(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	INITIAL COMMENTS An annual and complaint survey was completed on May 30, 2025. The complaint was unsubstantiated (Intake #NC00230259). No deficiencies were cited. The facility is licensed for the following service categories: 10A NCAC 27G .1100 Partial Hospitalization for Individuals who are acutely Mentally Ill and 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for six and has a current census of four. The 1st licensed category has a current census of four and the 2nd licensed category has a current census of four. The survey sample consisted of audits of two current clients, one deceased client in the 1st licensed category and two current clients, one deceased client in the 2nd licensed category.	V 000		