

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL029-103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/03/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DREAM MAKERS ASSISTED LIVING SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>168 ROY LOPP ROAD LEXINGTON, NC 27292</b>
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(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>A complaint and follow up survey was completed on December 3, 2025. The complaint was unsubstantiated (intake #NC00234473). 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 Disability.</p> <p>This facility is licensed for 3 and has a current census of 2. The survey sample consisted of audits of 2 current clients and 1 former client.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_