

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL032086	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/10/2025
NAME OF PROVIDER OR SUPPLIER ANGELICA HOUSES FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2007 STADIUM DRIVE DURHAM, NC 27705		
(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
{C 000}	Initial Comments Report by Kelly Myers Based on your acceptable Plan of Corrections received on January 8, 2025 for a Biennial Construction Complaint Survey, all previously cited deficiencies are noted as being corrected by photo documentation. Therefore no further action is required.	{C 000}		

Division of Health Service Regulation

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

TITLE

(X6) DATE