Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601357	A. BUILDING: _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOSEPH'S HOUSE OF CHARLOTTE	605 CLIFFS INN CIRCLE CHARLOTTE, NC 28214

(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 survey was attempted on 5/15/19. According to the Licensee there are no clients being served at the facility. The last time clients were served at the facility was July 2018. This facility is licensed for the following service category: 10A NCAC 27G 5600F Alternative Family Living According to the AFL Provider and licensee, the AFL's house burned down in July 2018. They completed an emergency relocation with the state and went to stay in a hotel until was able to move into new facility which is licensed by the state. They moved into another house in November 2018. The facility is still licensed. Its being rebuilt and they are planning to move back into it when finished. Surveyor will conduct survey on new licensed facility that clients are currently staying in.	V 000		

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