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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED				
711212711	or contraction	IDENTIFICATION NO MIDEN.	A. BUILDING: _						
		MHL0601328	B. WING		06/2	6/2019			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE					
HOPEWAY 1717 SHARON ROAD WEST CHARLOTTE, NC 28210									
(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		V 000						
	A follow-up survey was completed on 6/26/19. A deficiency was cited.								
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Mentally-III Adults								
V 131	G.S. 131E-256 (D2) H Verification	HCPR - Prior Employment	V 131						
	REGISTRY (d2) Before hiring hea health care facility or health care facility sha	alth care personnel into a service, every employer at a all access the Health Care and shall note each incident opriate business files.							
	failed to ensure the H Registry (HCPR) was	ew and interview, the facility							
	- A hire date of 7/2	staff #1's record revealed: 27/18 accessed on 11/29/18							
	Officer (COO) revealed - Around the time of Cotheir former human re	with the Chief Operations ed: Client #1's hire, they had lost esources director and hired were in transition and							

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
			A. BOILDING.									
MHL0601328			B. WING		06/26/2019							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
HOPEWAY CHARLOTTE NC 28210												
CHARLOTTE, NC 28210  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)												
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPL	)) LETE [E						
V 131	1 Continued From page 1		V 131									
	training											

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