

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601323	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2021
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NAME OF PROVIDER OR SUPPLIER DAVIS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 6914 CEDARCREEK DRIVE CHARLOTTE, NC 28215
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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>INITIAL COMMENTS</p> <p>An annual survey was attempted on 9/1/21. According to the Licensee, there are no clients being served at the facility.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living(AFL).</p> <p>Interview on 8/30/21 with the Licensee revealed: -AFL provider has moved from this location and no longer resides there; -has moved to another home and has obtained a new license; -his current license number is 060-1485 effective 6/25/21.</p> <p>Review on 9/1/21 of licensure records revealed: -the house with licensure #060-1323 is still current and has not been closed; -date of license for new location #060-1485 dated 6/25/21; -owner of both AFL sites and names and both licenses have same AFL provider with same phone number listed.</p> <p>Interview on 9/1/21 with AFL provider revealed: -stated he has moved from the location licensed 060-1323 and no longer resides there; -stated he still owns the home licensed 060-1323 and it is still licensed as he wants to open it as a respite home; -has told the Licensee he wants to change the service from AFL to respite for licensee 060-1323; -there are no clients residing at home licensed 060-1323; -is waiting on the Licensee to get service changed on that license; -has clients residing with him at home licensed</p>	V 000		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 000	Continued From page 1 060-1485.	V 000		