

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601445 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/30/2021 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER THE DUPONT HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 11007 DEKALB PLACE CHARLOTTE, NC 28262 |
|--|--|

| (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 8/30/21. 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</p> <p>Interview with the Licensee on 8/30/21 revealed: -no current clients at this facility; -not served any clients since being initially licensed.</p> | V 000 | | |

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