

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601407	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/22/2022
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NAME OF PROVIDER OR SUPPLIER MITCHELL FAMILY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 14331 EVENING FLIGHT LANE CHARLOTTE, NC 28262
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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 was attempted on 02/22/2022. According to the facility's Director of Operations there are no clients being served at the facility. The facility had not served clients since being licensed effective July 19, 2019.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>Interview on 02/22/2022 with the facility's Director of Operations revealed: -No clients served at facility in the past year or since license effective date. -"The Primary AFL staff is actively seeking AFL placements and we hope to have someone placed in the home within the next 6 months or we will have a serious discussion about rescinding the license".</p>	V 000		

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