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
	MHL0601323	A. BUILDING: _____ B. WING _____	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOME	6914 CEDARCREEK DRIVE CHARLOTTE, NC 28215

(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 3/1/22. According to the Qualified Professional(QP), there are no clients being served at the facility. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living(AFL). Interview on 3/1/22 with the QP revealed: -AFL provider no longer resides there; -no clients residing in that home. Interview on 3/1/22 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 wanted to open it as a respite home and get it licensed for respite; -now he is in process of finding another location to transfer the license to; -there are no clients residing at home licensed 060-1323.	V 000		

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