PRINTED: 04/08/2022 FORM APPROVED

Division of Health Service Regulation

| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANDED TO THE APPROPRIATE DEFICIENCY) PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANDED TO THE APPROPRIATE DEFICIENCY) | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| CLARISE BRYANT CHARLOTTE, NC 28215 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PS45 WEIKERT ROAD CHARLOTTE, NC 28215 ID PROVIDER'S PLAN OF CORRECTION (X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY) A DEFICIENCY | | MHL0601462 | B. WING | | 4/06/2022 | |
| CHARLOTTE, NC 28215 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CHARLOTTE, NC 28215 CHARLOTTE, NC 28215 ID PROVIDER'S PLAN OF CORRECTION (X COMPRESS PLAN OF CORRECTION SHOULD BE COMPRESS PLAN OF CORRECTION (X COMPRESS PLAN OF CORRECTION SHOULD BE COMPRESS PLAN OF CORRECTION (X COMPRESS PLAN OF CORRECTION SHOULD BE COMPRESS PLAN OF CORRECTION (X COMPRESS PLAN OF CORRECTION SHOULD BE COMPRESS PLAN OF CORRECTION SHOULD BE COMPRESS PLAN OF CORRECTION (X COMPRESS PLAN OF CORRECTION SHOULD BE COMPRESS PLAN OF CORRECTION (X COMPRESS PLAN OF CORRECTION SHOULD BE COMPRESS PLAN OF CORRECTION (X COMPRESS PLAN OF CORRECTION SHOULD BE COMPRESS PLAN OF CORRECTIO | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X COMPANY OF LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PROVIDER'S PLAN OF CORRECTION (X COMPANY OF LSC IDENTIFYING INFORMATION) | CLARISE BRYANT | | | | | |
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| V 000 INITIAL COMMENTS V 000 | V 000 INITIAL COMMENTS | | V 000 | | | |
| An annual survey was attempted on 4-6-22. According to the Director there are no clients being served at this facility. The last time clients were served at the facility was 3-11-22. This facility is licensed for the following service category: 10 A NCAC 27G 5600F Supervised Living For All Disability groups in a Private Residence. Interview on 4-6-22 with the Director revealed that the Alternative Family Living provider had to have surgery so they had to move the clients. At this point, she was unsure if they would be putting clients back at the facility | According to the Dire being served at this f were served at the fa. This facility is license category: 10 A NCAC Living For All Disabili Residence. Interview on 4-6-22 with the Alternative Family surgery so they had to point, she was unsured. | here are no clients The last time clients was 3-11-22. the following service 5600F Supervised tups in a Private The Director revealed that and provider had to have we the clients. At this | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE