STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601328	A. BUILDING: _____ B. WING _____	R 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEWAY	1717 SHARON ROAD WEST CHARLOTTE, NC 28210

(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 A complaint and follow-up survey was completed on 6/28/22. The complaints were unsubstantiated(Intakes #187189, #187525). No deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .1100 Partial Hospitalization for Individuals Who are Acutely Mentally Ill and 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 36 beds and currently has a census of 28. The survey sample consisted of 4 current clients and 2 former clients.	V 000		