

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-971 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/25/2022 |
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| NAME OF PROVIDER OR SUPPLIER TONY'S HELPING HAND | STREET ADDRESS, CITY, STATE, ZIP CODE 3925 FALLS RIVER AVENUE RALEIGH, NC 27614 |
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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 |
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| V 000 | <p>INITIAL COMMENTS</p> <p>An annual survey was completed on 8/25/22. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>This facility is licensed for 3 beds and currently has a census of 3. The survey survey sample consisted of audits 3 current clients.</p> | V 000 | | |

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