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
	MHL009-043	A. BUILDING: ______ B. WING ______	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINAS HOME CARE AGENCY INC	**1204 WEST SWANZY STREET ELIZABETHTOWN, NC 28337**

(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 and complaint survey was completed on February 1, 2023. The complaint was unsubstantiated (intake #NC00195738). No deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .1400 Day Treatment and .5400 Day Activity For Individuals Of All Disability Groups. This facility has a current census of 17 in the .5400 Day Activity For Individuals Of All Disability Groups program. The survey sample consisted of audits of 3 current clients. This facility has a current census of 0 in the .1400 Day Treatment program. Interview on 1/31/23 the Qualified Professional could not recall the last time a client had been admitted to the .1400 Day Treatment program, but it had been much longer than 12 months.	V 000		

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