STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL002-032	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGIE'S HELPING HAND	490 RADIO ROAD TAYLORSVILLE, NC 28681

(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 limited follow up survey for the Type B was completed on 2/28/24. This was a limited follow up survey, only 10A NCAC 27G.1701 (V293) with cross references 10A NCAC 27G.1702 (V294), 10A NCAC 27G.1704 (V296), 10A NCAC 27G.1705 (V297) and 10A NCAC 27G.1706 (V298) were reviewed for compliance. The following were brought back into compliance 10A NCAC 27G.1701 (V293) with cross references 10A NCAC 27G.1702 (V294), 10A NCAC 27G.1704 (V296), 10A NCAC 27G.1705 (V297) and 10A NCAC 27G.1706 (V298). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 5 and currently has a census of 1. The survey sample consisted of audits of 1 current client.	V 000		