

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>MHL0601493</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/21/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HELPING HANDS HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4734 PALUSTRIS COURT<br/>CHARLOTTE, NC 28269</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| V 000                                                         | <p><b>INITIAL COMMENTS</b></p> <p>An annual survey was completed on 11/21/24.<br/>No deficiencies were cited.</p> <p>This facility is licensed for the following service<br/>category: 10A NCAC 27G .5600F Supervised<br/>Living for Alternative Family Living.</p> <p>This facility is licensed 2 and has a current<br/>census of 2 The survey sample consisted of<br/>audits of 2 current clients.</p> | V 000                                                                                        |                                                                                                                          |                                                        |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE