

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL0601322</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>TRANSITIONS CHARLOTTE DAY PROGRAM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5309-B IDLEWILD ROAD N CHARLOTTE, NC 28227</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on January 3, 2025. The complaint was substantiated (intake #NC00223812). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5400 Day Activity for Individuals of all Disability Groups.</p> <p>This facility has a current census of 187. The survey sample consisted of audits of 1 current client.</p>	V 000			

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

TITLE

(X6) DATE