STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0921003	A. BUILDING: _____ B. WING _____	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SMITH HOME-A CARING HANDS SITE	2004 CAMPANA DRIVE RALEIGH, NC 27603

(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 survey was attempted on 2/14/25. According to the facility's case management (CM) office representative there are no clients being served at the facility. The last time clients were served at the facility she thought was summer 2024. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. Based on observation and interview revealed the following: - 11:24am: arrived to the facility & knocked on the door, no answer - 11:25am: telephone call to the Alternative Family Living (AFL) provider and left message - 11:26am: telephone call to the CM office: a representative reported no clients were being served at the facility	V 000		