

Division of Health Service Regulation

| | | | | | |
|---|--|--|--|--------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 220495 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | | (X3) DATE SURVEY COMPLETED 04/04/2025 |
| NAME OF PROVIDER OR SUPPLIER A SAFE HAVEN | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2117 CADENCE TRACE DRIVE CHARLOTTE, NC 28227 | | |
| (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>INITIAL COMMENTS</p> <p>An annual survey was completed on 4/4/25. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>This facility is licensed for 2 and has a current census of 1. The survey sample consisted of audits of 1 current client and 1 former client.</p> | V 000 | | | |

Division of Health Service Regulation

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

TITLE

(X6) DATE