

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL060-381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>VILLAGES OF HOPE HAVEN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3815 NORTH TRYON STREET</b> <b>CHARLOTTE, NC 28206</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>An annual and follow up survey was completed on 4/11/25. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .4100 Residential Recovery Programs for Individuals with Substance Abuse Disorders and Their Children and 10A NCAC 27G .4300 Therapeutic Community.</p> <p>This facility is licensed for 140 and has a current census of 100. The survey sample consisted of audits of 10 current clients.</p>	V 000		

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

TITLE

(X6) DATE