STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL002-032	A. BUILDING: _____ B. WING _____	R 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGIE'S HELPING HAND	490 RADIO ROAD TAYLORSVILLE, NC 28681

(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 and follow up survey was attempted on June 4, 2025. According to the Director, there are no clients being served at the facility. The last time clients were served at the facility was August 2, 2024. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. Observation on 6/3/25 at approximately 12:15 pm revealed: -Two men were present at the facility on the front porch and identified themselves as maintenance men. -Several machine tools, including an electric skill saw, was on the front porch. Review on 6/3/25 of Former Client #1's record revealed: -Age: 17 -Date of Admission: 4/30/24 -Date of Discharge: 8/2/24 -Diagnosis: Unspecified Psychosis Interview on 6/3/25 with the Director revealed: -The facility was not currently serving clients. -The last client served was in August of 2024. -Was currently in the process of making repairs to the facility. -Was "...currently in the process of accepting referrals and screening prospective clients for admission..."	V 000		