Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL0601369 | A. BUILDING: _____ B. WING _____ | R 07/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW BEGINNINGS HOME | 6619 FARRINGTON LANE 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 | INITIAL COMMENTS<br><br>A follow up survey was attempted on 7/18/25. According to the Director there are no clients being served at the facility. The last time clients were served at the facility was 9/14/24.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.<br><br>Interview on 7/18/25 with the Director revealed:<br>-The facility was still operating, but there were no clients there at this time.<br>-Last client was discharged on 9/14/24. | V 000 | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE