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 _____	07/18/2025

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 7/18/25. According to the facility's Residential Manager no clients were served at the facility this year (2025). This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. Attempted telephone call on 7/18/25 with the Alternative Family Living Provider revealed no answer Interview on 7/18/25 with the RM revealed: - did not have access of when the last client was served at the facility - confirmed no clients had been served at the facility this year (2025)	V 000		