

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601538	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/24/2025
NAME OF PROVIDER OR SUPPLIER WINGS GROUP HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6346 MORNINGVIEW COURT CHARLOTTE, NC 28269		
(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 and follow-up survey was attempted on 7/24/25. According to the Owner, there are no clients being served in the facility. The last time clients were served at the facility was 12/27/23.</p> <p>The facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability.</p> <p>Interview on 7/24/25 with the Owner revealed:</p> <ul style="list-style-type: none"> -No clients had been served since the last attempted survey on 3/28/25; -"We were trying to move (to a different location); -We got the ceiling repaired; -We're going to go ahead and take somebody so we don't mess up our license." 	V 000		

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

TITLE

(X6) DATE