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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					С	
		MHL023-210	B. WING		08/27/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KAREN'S	CARE HOME	435 BORE	ERS ROAD			
IVAILLII O	OAKE HOME	SHELBY,	NC 28152			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	2020. The complaint NC00167156). A defi	d for the following service 27G .5600F Supervised				
V 289	27G .5601 Supervise	d Living - Scope	V 289			
	provides residential shome environment where services is the rehabilitation of indivivillness, a development or a substance abuse supervision when in the facility serves eith (1) one or more (2) two or more (2) two or more (2) two or more (3) two or more (4) two or more (5) two or more (6) two or more (7) two or more (8) two or more (9) two or more (10) two or more (11) two or more (12) two or more (13) two or more (14) two or more (15) two or	is a 24-hour facility which ervices to individuals in a here the primary purpose of care, habilitation or duals who have a mental ntal disability or disabilities, e disorder, and who require he residence. In facility shall be licensed if her: It minor clients; or e adult clients. Its shall not reside in the				

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

(X6) DATE TITLE

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DIVISION	n nealth Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
					_	<u> </u>
			P WING		C	
		MHL023-210	B. WING		08/2	7/2020
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE		
	1011211 011 001 1 21211					
KAREN'S	CARE HOME		ERS ROAD			
		SHELBY, I	NC 28152			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	NAIE	DAIL
				,		
V 289	Continued From page	e 1	V 289			
	(4) "D" designa	tion means a facility which				
	serves minors whose					
		endency but may also have				
	other diagnoses;	chacilly but may also have				
		tion means a facility which				
	serves adults whose					
	•					
		endency but may also have				
	other diagnoses; or	tion manage of calltoning				
	(6) "F" designation means a facility in a					
	•	ich serves no more than				
	three adult clients whose primary diagnoses is					
	mental illness but ma	-				
	disabilities, or three adult clients or three minor					
	clients whose primary diagnoses is					
	developmental disabilities but may also have					
		live with a family and the				
		ervice. This facility shall be				
		wing rules: 10A NCAC 27G				
	.0201 (a)(1),(2),(3),(4)),(5)(A)&(B); (6); (7)				
	(A),(B),(E),(F),(G),(H)	; (8); (11); (13); (15); (16);				
		AC 27G .0202(a),(d),(g)(1)				
	(i); 10A NCAC 27G .0	203; 10A NCAC 27G .0205				
		G .0207 (b),(c); 10A NCAC				
		A NCAC 27G .0209[(c)(1) -				
	. , . , .	ications only] (d)(2),(4); (e)				
		and 10A NCAC 27G .0304				
		ility shall also be known as				
		g or assisted family living				
		g or assisted fairling living				
	(AFL).					
	T . B					
	This Rule is not met					
		nd record review, the facility				
	_	ensure minor and adult				
	clients did not reside	within the same facility. The				
	findings are:					

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Division	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
			_		
					C
		MHL023-210	B. WING		08/27/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		435 BOR	DERS ROAD		
KAREN'S	CARE HOME		NC 28152		
		SHELD1,	NC 20132		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(710)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
				DEI IOIENOT)	
V 289	Continued From page	. 2	V 289		
V 203	Continued From page	;	V 209		
	Review on 8/19/20 of	the facility file revealed:			
		1/17/19 granted the facility			
		-			
		ents and adults within the			
	same facility.				
	-the waiver was appro	oved for the licensure year			
	2019.				
	-"In accordance witl	h 10A NCAC 27G .0813, the			
		CAC 27G.5601 (b) cannot			
		, ,			
	exceed the expiration date of the 2019 license which is December 31, 2019; and, therefore shall be subject to renewal consideration upon the request of the licensee" -there was no waiver letter granting this for the				
	licensure year 2020.				
	Davious on 9/20/20 of the facility's license gurrent				
	Review on 8/20/20 of the facility's license, current and former client records revealed:				
	-the facility was licens				
	-Client #1 - admitted :	5/31/17 - 17 years old.			
	-Client #2 - admitted 5/31/17 - 20 years old.				
	-Former Client #3 - admitted 5/30/17 - discharged				
	7/17/20 - 19 years old as of March 2020.				
	1711720 10 yours or	. 45 51 March 2025.			
	Interview on 8/24/20 v	with the Director of			
		with the Director of			
	Operations revealed:				
		waiver approval process but			
	had been going back	and forth with the Local			
	Management Entity (I	_ME).			
		license changed from a	1		
	child home to an adul	-	1		
		ne AFL provider wanted to			
		•			
	-	she had put the process on			
	hold.				
		and continue the waiver			
	request process and i	notify DHSR if/when she			
	was no longer the lice				
		· · · · · · · · · · · · · · · · · · ·			

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