

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-938</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/18/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PAUL'S LOVING CARE, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1114 SHAW ST BURLINGTON, NC 27217</b>
--	---

(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><b>INITIAL COMMENTS</b></p> <p>An annual survey was attempted on October 18, 2021.</p> <p>According to the Licensee there are no current clients receiving services at the facility. The last time clients resided at the facility was in October 2020.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>Observations on 10/18/21, at approximately 12:22pm, of the outside of the facility revealed:                      -The trash can was at the curb                      -Numerous trees and dead leaves were in the yard                      -Mail was overflowing inside the mail box attached to the facility                      -A trick or treat sign was in the front left window                      -A CARF (Commission on Accreditation of Rehabilitation Facilities) sign was in the front right window.                      -All the blinds in the facility's windows were drawn.                      -Ivy was growing on the side of the facility                      -A television was on inside the facility                      -There was no answer to the knocking on the front, side or back door.</p> <p>Interview on 10/18/21 with an anonymous neighbor revealed:                      -The home was a group home                      -There had not been any clients at the facility "in quite some time."                      -"There were some people there yesterday that were either moving in some furniture or moving out some furniture. I could not tell which."</p>	V 000		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-938</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/18/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PAUL'S LOVING CARE, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1114 SHAW ST BURLINGTON, NC 27217</b>
--	---

(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>Continued From page 1</p> <p>Interview on 10/18/21 with the Licensee revealed:</p> <ul style="list-style-type: none"> <li>-No clients had received services at the facility since October 2020.</li> <li>-Did not understand why she was unable to get any clients</li> <li>-"I just don't understand it."</li> <li>-Her Agency was kept "a float" by a client that was receiving Supportive Living Services</li> <li>-"He does not reside at the facility, he resides in his private residence."</li> <li>-Planned to keep her Licensee through the end of 2021.</li> <li>-"I know I can't renew my license if I don't have any clients by the end of the year."</li> </ul>	V 000		