STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			A. BOILDING.				
		MHL076-135	B. WING		02/2	28/2022	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
CAROL'S	S FAMILY CARE		HBROOK CIR( ALE, NC 27263	CLE ARCHDALE 3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE	
V 000	INITIAL COMMENT	rs	V 000				
	on February 28, 20, substantiated (intak Deficiency was cite This facility is licens	aplaint survey was completed 22. The complaint was (e #NC00186146). A d. sed for the following service C 27G .5600F Supervised					
	Living: Alternative F Residence.	Family Living in a Private					
	The survey wasmpl current clients.	le consisted of audits of 3					
V 289	27G .5601 Supervis	sed Living - Scope	V 289				
	provides residential home environment these services is th rehabilitation of indi illness, a developm or a substance abu supervision when ir (b) A supervised liv the facility serves e	ng is a 24-hour facility which I services to individuals in a where the primary purpose of le care, habilitation or ividuals who have a mental ental disability or disabilities, se disorder, and who require in the residence. ving facility shall be licensed if ither:					
	<ul> <li>(2) two or mo</li> <li>Minor and adult clie</li> <li>same facility.</li> <li>(c) Each supervise</li> </ul>	ore minor clients; or ore adult clients. ents shall not reside in the ed living facility shall be					
	designated below: (1) "A" design serves adults whos	specific population as nation means a facility which e primary diagnosis is mental					
	(2) "B" design serves minors who	b have other diagnoses; nation means a facility which se primary diagnosis is a ability but may also have other					

1GCB11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MUL 070 425	B. WING		20/00/0000	
		MHL076-135			02/	28/2022
	ROVIDER OR SUPPLIER		DDRESS, CITY, S <sup>-</sup> HBROOK CIR(	CLE ARCHDALE		
CAROL'S	FAMILY CARE		LE, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 289	Continued From pa	ige 1	V 289			
	serves adults whos developmental disa diagnoses; (4) "D" desigi serves minors whos substance abuse d other diagnoses; (5) "E" desigi serves adults whos substance abuse d other diagnoses; or (6) "F" desigi private residence, w three adult clients w mental illness but n disabilities, or three clients whose prima developmental disa other disabilities wf family provides the exempt from the fo .0201 (a)(1),(2),(3), (A),(B),(E),(F),(G),( (18) and (b); 10A NCAC 27G .0208 (b),(e); non-prescription me (1)(A),(D),(E);(f);(g) (b)(2),(d)(4). This f alternative family liv (AFL).	hation means a facility in a which serves no more than whose primary diagnoses is nay also have other e adult clients or three minor ary diagnoses is abilities but may also have no live with a family and the service. This facility shall be llowing rules: 10A NCAC 27G (4),(5)(A)&(B); (6); (7) H); (8); (11); (13); (15); (16); CAC 27G .0202(a),(d),(g)(1) .0203; 10A NCAC 27G .0205 27G .0207 (b),(c); 10A NCAC 10A NCAC 27G .0209[(c)(1) - edications only] (d)(2),(4); (e) ); and 10A NCAC 27G .0304 facility shall also be known as <i>v</i> ing or assisted family living				
	This Rule is not me	et as evidenced by:				

1GCB11

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL076-135 B. WING			02/28/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	ATE, ZIP CODE		
CAROL'S	S FAMILY CARE		HBROOK CIRC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 289	Continued From pa	ge 2	V 289			
	Based on interview and record review, the facility management failed to ensure minor and adult clients did not reside within the same facility. The findings are:					
	Review on 2/21/22 of the facility license revealed the facility is licensed as a 5600F Supervised Living Facility. Review of the Rules for Mental Health Developmental Disabilities and Substance Abuse Facilities and Services revealed "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service.					
	-Admission date of company.) -Client #1 was 30 y -Diagnoses of Mode Personality Disorde Conduct D/O; Majo severe without Psyc Thrombocytopenia,	erate IDD; Antisocial r; ADHD, Combined Type; r Depressive D/O, Recurrent,				
	-Admission date of company.) -Client #2 was 24 y -Diagnoses of Atter	ntion Deficit Hyperactivity d Presentation; Mild				

	of Health Service Re					
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	MHL076-135		B. WING		02/28/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		6136 AS	HBROOK CIRC	CLE ARCHDALE		
CAROLS	S FAMILY CARE	ARCHDA	LE, NC 27263	3		
(X4) ID			ID			(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETI DATE
V 289	Continued From pa	ige 3	V 289			
	-Admission date of	11/8/21.				
	-Client #3 was 17 y					
		Intellectual Developmental				
	Disability, Autism D					
	Review on 2/21/22	of the facility file revealed:				
	-A waiver letter dated 11/5/21 granted the facility					
	to serve both adolescents and adults within the					
	same facility.					
	-The waiver was approved for the licensure year					
	2021.					
	-"In accordance with 10A NCAC 27G .0813, the					
	waiver of Rule 10A NCAC 27G.5601 (b) and Rule					
	10A NCAC 27G .5601 (c) (6) cannot exceed the					
	expiration date of the 2021 license which is December 31, 2021; and, therefore shall be					
	subject to renewal consideration upon the request of the licensee" -There was no waiver letter granting this for the		t			
	licensure year 2022	2.				
	Interview on 2/22/2	2 with the Qualified				
	Professional reveal					
		at Client #3 was an				
	adolescent. -Prior for him starti	ng at the house, they had				
	submitted an "age					
		een approved and client was				
	placed at the home					
		out to turn 18 in March 2022.				
		ware that they needed to				
		er after December 2021.				
		e impression that the waiver				
	was going to be go which was going to	od until Client #3's birthday be in March 2022				
		ent #3 was a minor and				
		with other adult residents.				
		agency failed to renew waiver				
		for a minor to reside along				
	adults at the same					1

Division of Health Service Regulation           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIE           AND PLAN OF CORRECTION         IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		BENTH IOA TOMBER.	A. BUILDING:			
		MHL076-135	B. WING		02/	28/2022
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, ST			
CAROL'S FAMILY CARE 6136 ASHBROOK CIRCLE ARCHDALE ARCHDALE, NC 27263						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE