STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-246	A. BUILDING: _____ B. WING _____	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILLE'S PLACE	1573 SOUTH OAK DRIVE SHELBY, NC 28150

(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 June 16, 2025. According to the Owner there are no clients being served at the facility. No clients have been served at this facility since initial licensure in 2024. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. Interview on 6-16-25 with the Owner revealed: -Had not served any clients since becoming licensed. -The clients that the Local Management Entity/Managed Care Organization (LME/MCO) had been referring were not good fits for her household. -Understood that she needed to serve clients in order for her licensure to be renewed annually.	V 000		