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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NO.	A. BUILDING:			
	MHL059-118 B. WING		C 07/09/2025			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOWAN H	IOME		E TAHOMA RO NC 28752	AD		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	2025. The complaint (NC#00231691). A d This facility is license category: 10A NCAC	eficiency was cited. d for the following service 27G .5600F Supervised				
	-	d for 3 and has a current vey sample consisted of				
V 289	V 289 27G .5601 Supervised Living - Scope		V 289			
	provides residential s home environment withese services is the rehabilitation of indiviillness, a developmer or a substance abuse supervision when in t (b) A supervised living the facility serves eith (1) one or more (2) two or more (2) two or more Minor and adult client same facility. (c) Each supervised licensed to serve a specification of the serves adults whose illness but may also he (2) "B" designated serves minors whose	is a 24-hour facility which ervices to individuals in a here the primary purpose of care, habilitation or duals who have a mental stal disability or disabilities, a disorder, and who require the residence. If facility shall be licensed if ther: It is a minor clients; or a adult clients. It is shall not reside in the living facility shall be pecific population as				

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7t. Boilbiito.		С	
		MHL059-118	B. WING		07/09/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOWAN H	IOME		TAHOMA RO	AD		
	OLIMAN DV OT	MARION, N		DDO//DEDIG DLAN OF GODDEGTIO		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 289	Continued From page	e 1	V 289			
	(3) "C" designal serves adults whose developmental disabilitiagnoses; (4) "D" designal serves minors whose substance abuse depother diagnoses; (5) "E" designal serves adults whose substance abuse depother diagnoses; or (6) "F" designal private residence, whose there adults clients whose private residence, whose private residence, whose primary developmental disabilities, or three a clients whose primary developmental disabilities who family provides the seexempt from the following pr	tion means a facility which primary diagnosis is a lity but may also have other tion means a facility which primary diagnosis is sendency but may also have tion means a facility which primary diagnosis is sendency but may also have tion means a facility which primary diagnosis is sendency but may also have tion means a facility in a ich serves no more than ose primary diagnoses is y also have other dult clients or three minor or diagnoses is lities but may also have live with a family and the ervice. This facility shall be wing rules: 10A NCAC 27G				
	This Rule is not met	as evidenced by:				

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		IDENTIFICATION NUMBER:	A. BUILDING: _			
		MHL059-118	B. WING		07/09/2025	
NAME OF B	20,425, 02, 01, 125, 155	0.70557.11		TE 710 0005		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	,		
GOWAN H	IOME		KE TAHOMA RO	AD		
		MARION	, NC 28752			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(- /	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI		
				DEFICIENCY)		
V 289	Continued From page	. 2	V 289			
V 200	Continued From page	. 2	V 203			
		ew and interview, the facility				
	•	ervices within the scope of				
	•	2 of 2 former clients (FC #1				
	and FC #2). The find	ings are:				
	Davious on 6/25/25 of	the Division of Health				
		facility licensure records				
	revealed:	dollity licerisare records				
	-Facility Type: 5600F Supervised Living/Alternative Family Living with a capacity of 3.					
	-Change of Ownershi	p for the license effective				
	2/12/25 from the former licensee to Shine					
	Support Services Cor	poration.				
	Daview en 0/07/05 ef	FC #415 *** cond **** colod:				
	-Date of Admission: 2	FC #1's record revealed:				
	-Date of Discharge: 5					
	•	Disorder (D/O), unspecified;				
		D, recurrent, unspecified;				
	Intermittent Explosive					
	Developmental Disab	ility, Moderate; Attention				
		Disorder (ADHD), combined				
	type; and Allergic Rhi					
		s: "Guardian of member				
	chose to go with anot	ner provider."				
	Review on 6/27/25 of	FC #2's record revealed:				
	-Date of Admission: 2					
	-Date of Discharge: 5					
	_	O due to physiological				
		d; Disruptive Behavior D/O;				
		oathic Epilepsy and Epileptic				
	•	lectual Developmental				
	Disability, Moderate.	110 II 6 I				
		s: "Guardian of member				
	chose to go with anot	ner provider."				
	Interview on 6/26/25	with the Alternative Family				

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Living Provider (AFL) revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED			
					С	
MHL059-118			B. WING 07/09/202			_
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
GOWAN I	HOME		KE TAHOMA ROA I, NC 28752	AD		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET	Ξ
V 289	-Had received 2 facility the former licensee in the current licensee in Interview on 6/25/25 at Licensee revealed: -Not providing services	ry licenses in 2025; 1 from January 2025 and 1 from n February 2025.	V 289			

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