

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL023-048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/17/2025
NAME OF PROVIDER OR SUPPLIER CHARLES ROAD A		STREET ADDRESS, CITY, STATE, ZIP CODE 829-1 CHARLES ROAD A SHELBY, NC 28152		
(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 and follow up survey was attempted on September 17, 2025. According to the Regional Director there are no clients being served at the facility. The last time clients were served at the facility was February 10, 2025. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. Interview on 9/17/25 with the Regional Director revealed: -There were no clients currently residing at the facility. -No new admissions had occurred since the previous survey attempt conducted on April 9, 2025. -The facility had not served clients since February 10, 2025.	V 000		

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

TITLE

(X6) DATE