STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G251	A. BUILDING _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAREN LANE HOME	3224 KAREN LANE MONROE, NC 28112

(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) COMPLETION DATE
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 3 audited clients (#5) received a continuous active treatment program consisting of needed interventions as identified in the person-centered plan (PCP). The finding is: Observation in the group home on 12/3/25 at 7:58 AM revealed client #5 to enter the medication room for medication administration. Continued observation revealed staff to retrieve and identify each of the client's medications before popping them into a medication cup. Further observation revealed staff to hand client #5 the medication cup and a glass of water, and for the client to take her medication independently. At no time was client #5 offered an opportunity to participate in her medication administration. Review of client #5's record on 12/3/25 revealed a PCP dated 5/30/25 which indicated a training objective for the client to participate in medication administration by pressing the correct medication out of the blister pack at 90% accuracy with no more than one partial physical prompt for three	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G251	A. BUILDING _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAREN LANE HOME	**3224 KAREN LANE MONROE, NC 28112**

(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) COMPLETION DATE
W 249	Continued From page 1 consecutive months. Interview with the qualified intellectual disability professional (QIDP) on 12/3/25 confirmed client #5's training objectives are current. Continued interview with the QIDP confirmed staff should have provided client #5 the opportunity to participate in her medication administration.	W 249		