

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 05/20/2026
--	---	---	---

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	<p>INITIAL COMMENTS</p> <p>An annual survey was attempted on May 20, 2026. According to the Qualified Professional there are no clients being served at the facility. The last time clients were served at the facility was February 10, 2025.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>Interview on 5/20/26 with the Qualified Professional revealed: -There were no clients currently residing at the facility. -There had not been admissions to the facility. -They were "still looking at admitting clients..." -The facility had not served clients since February 10, 2025.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------