PRINTED: 09/15/2023 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED						
74101 1244	N CONNECTION	IDEITH IO/HIOH HOMBER.	A. BUILDING: _			125					
		MHL080-214	B. WING		R 09/15	5/2023					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
TGH RESIDENTIAL SERVICES  328 OLD CONCORD ROAD  SALISBURY, NC 28144											
(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)  COMPLET DATE							
V 000	INITIAL COMMENTS		V 000								
	A follow up survey was Deficiencies were cite	as completed on 9/15/23. ed.									
		d for the following service 27G .1700 Residential re for Children or									
		d for 4 and currently has a rey sample consisted of ents.									
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736								
		EMENTS									
	This Rule is not met Based on observation was not maintained in manner. The findings	n, and interviews, the facility n a safe, and orderly									
		n floor revealed: gged and sloped down in an imately 4 feet by 4 feet in									
	and rip out the kitcher process of repairing t										

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED						
	MHL080-214	B. WING		00	R / <b>15/2023</b>						
NAME OF PROVIDER OR SUPPLIER			ZIP CODE	09	113/2023						
328 OLD CONCORD ROAD											
TGH RESIDENTIAL SERVICES SALISBURY, NC 28144											
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE						
- Due to the landlord r floor she applied to re - She had contacted E licensing know she wa home She was waiting on a landlords regarding he would then relocate the linterview on 9/15/23 v - She had been told by (kitchen) flooring." - The group home did 2022. The landlord was repairs to the group he admitted, but the land repairs.	trepair it (kitchen subfloor)." refusing to repair the kitchen ent other homes. DHSR licensing to let anted to relocate the group approval from other er rental application and ne group home.  with the Licensee revealed: y the landlord "not to fix the not have clients for part of as supposed to make ome prior to clients being llord never made the	V 736									

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