PRINTED: 06/13/2024 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLE	ILED				
		MHL029-152	B. WING		06/1	2/2024				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
44 CEDAR	LODGE A		LODGE ROAD LLE, NC 2736							
(V4) ID	SUMMARY ST		, 	PROVIDER'S PLAN OF CORRECTION	J	(Y5)				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	CH CORRECTIVE ACTION SHOULD BE COMPLESS-REFERENCED TO THE APPROPRIATE DATE					
V 000	INITIAL COMMENTS		V 000							
	An annual survey was completed on 6/12/24. A deficiency was cited.									
	This facility is licensed for the following category:10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.									
	•	d for 2 and has a current yey sample consisted of ents.								
V 114	2114 27G .0207 Emergency Plans and Supplies		V 114							
	AND SUPPLIES  (a) A written fire plan area-wide disaster plashall be approved by authority.  (b) The plan shall be and evacuation proceposted in the facility.  (c) Fire and disaster coshall be held at least repeated for each shi under conditions that	an shall be developed and								
	facility failed to ensure	ew and interviews, the								

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

(X6) DATE TITLE

PRINTED: 06/13/2024 FORM APPROVED

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						
		MHL029-152	B. WING		06	/12/2024						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
44 CEDAR LODGE A 44 CEDAR LODGE ROAD #A THOMASVILLE, NC 27360												
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETE DATE							
V 114	Continued From page 1		V 114									
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)											

Division of Health Service Regulation

STATE FORM 8YPJ11 If continuation sheet 2 of 2