

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION     |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>MHL005-029</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>02/11/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JOHNSON HOME</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1042 CABBAGE CREEK ROAD</b><br><b>CRESTON, NC 28615</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG                                | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE   |
| V 000   | <p><b>INITIAL COMMENTS</b></p> <p>An annual and follow up survey was completed on February 11, 2025. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>This facility is licensed for 2 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.</p> | V 000   |  |  |

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

TITLE

(X6) DATE