| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED R-C | |
|---------------|---|---|---|--|--------------------------------------|-----------------|
| | | | | | | |
| | | MHL064-162 | B. WING | | | 03/2025 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | HEALTHCARE SERVI | CES INC III | GERTY TRAIL | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF (| CORRECTION | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | COMPLET DATE |
| V 000 | INITIAL COMMENTS | | V 000 | | | |
| | A complaint and follow-up survey was completed on 3/3/25. The complaints were unsubstantiated (intake #NC00226185 and #NC00226412). A deficiency was cited. | | | | | |
| | This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. | | | | | |
| | | sed for 5 and has a current urvey sample consisted of clients. | | | | |
| V 784 | 27G .0304(d)(12) Therapeutic and Habilitative Areas | | V 784 | | | |
| | EQUIPMENT (d) Indoor space reprior to October 1, square footage req time. Unless otherwork residential facilities 1988 shall meet the requirements: (12) The area in whother the second | 804 FACILITY DESIGN AND equirements: Facilities licensed 1988 shall satisfy the minimun uirements in effect at that vise provided in these Rules, licensed after October 1, e following indoor space hich therapeutic and s are routinely conducted shall leeping area(s). | 1 | | | |
| | Based on record re interviews, the facil which therapeutic a | et as evidenced by: eview, observation and lity failed to ensure the area in and habilitative activities were d was separate from sleeping s are: | | | | |
| | Observation at 10: - A large closet t ealth Service Regulation | 34 am revealed: being used for storage | | | | |

| Division of Health Service Re STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | | (X3) DATE SURVEY COMPLETED R-C 03/03/2025 | |
|--|--|---|---|--|--|--|
| | | MHL064-162 | | | | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| OODY | HEALTHCARE SERVI | CES INC III | GERTY TRAIL MOUNT, NC 2 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT 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 | TION SHOULD BE COMPLE THE APPROPRIATE DATE | |
| V 784 | Continued From pa | ge 1 | V 784 | | | |
| | accessible by a door from the living room - No bedroom identified as a staff bedroom | | | | | |
| | Regulation (DHSR) 4/25/24 revealed: - "1.) At the time that the home has g construction since t 21, 2021. The Exte converted to a staff meet North Carolina bedrooms which re measure at least 7 and two means of e with the rule. Take the permits and building channels were take *It was observe storage room is no bedroom. The owne | ed during the survey that the longer being utilized as a staf er wants to convert the storag submit plans to DHSR and | t 9 | | | |
| | 2024 Her shifts include There was no set to a se | king at the facility in August ded sleep shifts staff bedroom at the facility ge closet had previously been room | 1 | | | |
| | before until they (fa need to make it larg - The facility was was not large enou- - She was sleepi | bing in the storage space cility staff) realized we (facility ger and more comfortable" s told that the storage closet gh to be a bedroom ng in the living room on a fold prage closet can be renovated | | | | |
| | Interview on 2/27/2 | 5 the Supervisor reported: | | | | |

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| AND PLAN OF CORRECTION IDENTI | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | | (X3) DATE SURVEY COMPLETED R-C 03/03/2025 | |
|-------------------------------|--|---|---|--|--|-------------------------|
| | | MHL064-162 | | | | |
| AME OF | PROVIDER OR SUPPLIER | | ADDRESS, CITY, S | TATE, ZIP CODE | | |
| | | 781 HA | GGERTY TRAIL | | | |
| | HEALINCARE SERVI | ROCKY | MOUNT, NC 2 | 7803 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | 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 DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| V 784 | Continued From page 2 | | V 784 | | | |
| | The Licensee " another provider The previous p not need a staff be The staff were room of the facility Interview on 2/27/2 There was curre The facility was as the staff bedroon not large enough to She is in the price of the plans would be construction for ap | "took over the license" from provider worked shifts and did droom currently sleeping in the living 25 the Licensee reported: rently no staff bedroom s using the large storage close m but were told that room was be a bedroom rocess of renovating the large bedroom contractor to the facility 2 s waiting for the construction sived the construction plans, submitted to DHSR oproval bing on a folding bed in the | et s | | | |

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