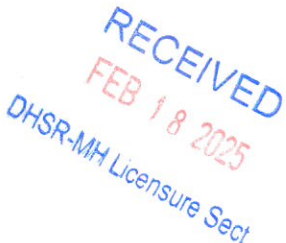


Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL024-043</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>GP ROAD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2838 GEORGIA PACIFIC ROAD CHADBOURN, NC 28431</b>		
(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	INITIAL COMMENTS  An annual survey was completed on January 29, 2025. A deficiency was cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.  This facility is licensed for 3 and has a current census of 2. The survey sample consisted of audits of 2 current clients.	V 000		3/28/2025
V 736	27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.  This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:  Observation on 1/28/25 between 10:22am - 11am a tour of the facility revealed: -The kitchen flooring in front of sink area was missing and exposed plywood. The area was covered by an area rug approximately 3 x 5 feet. -The hallway bathroom was missing flooring and exposed plywood. The toilet was removed and was placed in the bathroom. -Client #1's bathroom had cracked tile floor next to the toilet.  Interview on 1/28/25 the Program Manager stated: -She submitted a work order for the floors.	V 736		

Division of Health Service Regulation

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

*Dwight Hogg* MAOP

TITLE

*Qm Director*

(X6) DATE

*2/11/2025*

STATE FORM

6899

1TFX11

If continuation sheet 1 of 2

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL024-043</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>GP ROAD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2838 GEORGIA PACIFIC ROAD CHADBOURN, NC 28431</b>		
(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 736	Continued From page 1  -She could not recall when flooring was removed.  Interview on 1/28/25 the Clinical Supervisor stated: -The facility was waiting on their Environmental Health and Safety Director to provide a response on the status of the repairs.	V 736	<p style="text-align: center; color: blue; font-size: 1.2em;">RECEIVED</p> <p style="text-align: center; color: red; font-size: 1.2em;">FEB 18 2025</p> <p style="text-align: center; color: blue; font-size: 1.2em;">DHSR-MH Licensure Sect</p>	