PRINTED: 04/09/2025 FORM APPROVED

Division of Health Service Regulation

| MHL029-007 NAME OF PROVIDER OR SUPPLIER PATH OF HOPE, INC STREET ADDRESS, CITY, STATE, ZIP CODE 1675 EAST CENTER STREET EXT LEXINGTON, NC 27292 | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--|--------------|--|----|-------------------------------|--|
| PATH OF HOPE, INC 1675 EAST CENTER STREET EXT LEXINGTON, NC 27292 | | | MHL029-007 | B. WING | | 04 | /09/2025 | |
| PATH OF HOPE, INC LEXINGTON, NC 27292 | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | |
| | PATH OF HOPE, INC | | | | | | | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI | | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (X5) IX (EACH CORRECTIVE ACTION SHOULD BE COMPLET CROSS-REFERENCED TO THE APPROPRIATE DATE | | COMPLETE | |
| V 000 INITIAL COMMENTS V 000 | V 000 | 000 INITIAL COMMENTS | | V 000 | | | | |
| An annual and complaint survey was completed on April 9, 2025. The complaints were unsubstantiated. (Intake #NC00225588 and Intake #NC00228290). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 3400 Residential Treatment/Rehabilitation for individuals with Substance Abuse Disorders. This facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 3 current clients. | | on April 9, 2025. The unsubstantiated. (Inta Intake #NC00228290 cited. This facility is licensed category: 10A NCAC Treatment/Rehabilitat Substance Abuse Distributed This facility is licensed census of 4. The surv | complaints were ake #NC00225588 and). No deficiencies were d for the following service 27G .3400 Residential tion for Individuals with corders. d for 6 and has a current rey sample consisted of | | | | | |

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

TITLE (X6) DATE