Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-269	A. BUILDING: _____ B. WING _____	C 07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE HOME	320 WEST HUDSON BOULEVARD GASTONIA, NC 28054

(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 A complaint survey was attempted on 7-3-25. According the the Director there are no clients being served at the facility. Th last time clients were served at the facility was 5-20-25. This facility is licensed for the following service category: 10A NCAC 27G .1700 Supervised Living Staff Secure for Children or Adolescents. Interview on 7-3-25 with the Director revealed: -The facility has not had clients in over 45 days (5-20-25). -"One client was discharged in March 2025 and one client was moved to a sister facility in April 2025 and the last client was discharged on 5-20-25." -She is not sure when new clients will be admitted into the facility. -"We usually don't do intakes (admissions) when school is out. We are getting some referrals but none that appropriate for that home."	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE