R	Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
Image: Provider or supplier STREET ADDRESS, CITY, STATE, ZIP CODE BURKHEAD GROUP HOME 411 WEST BURKHEAD STREET WHITEVILLE, NC 28472 WHITEVILLE, NC 28472 (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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {V 000} INITIAL COMMENTS {V 000} A follow up survey was completed on 01/16/19. No deficiencies were cited. {V 000} This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised {V 000}				A. BUILDING:				
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