

Division of Health Service Regulation

|   |   |  |  |  |
|---|---|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>MHL024064</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/25/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HONEY HILL RESIDENTIAL</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>24 LAKELAND CIRCLE<br/>HALLSBORO, NC 28442</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| V 000   | <p><b>INITIAL COMMENTS</b></p> <p>An annual survey was completed on October 25, 2019. No deficiencies were cited</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> | V 000  |  |  |

Division of Health Service Regulation

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

TITLE

(X6) DATE