STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-192	A. BUILDING: _____ B. WING _____	R 12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA BEHAVIORAL HEALTH, PLLC	**1606 PHYSICIANS DRIVE, SUITE 103 & 104 WILMINGTON, NC 28401**

(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, complaint, and follow up survey was completed 12/21/21. The complaint was unsubstantiated (NC00183920). No Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .1100 Partial Hospitalization for Individuals Who Are Acutely Mentally Ill and 10A 27G .4400 Substance Abuse Intensive Outpatient Program. The sample consisted of audits of 2 current clients and 1 deceased client.	V 000		