| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL054-175 | A. BUILDING: _____ B. WING _____ | 05/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WITH A PURPOSE FAMILY CARE #2 - WOODY | 863 BLACK HARPER RD KINSTON, NC 28501 |

| (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<br><br>An annual survey was attempted on May 18, 2022. According to the Licensee there are no clients being served at the facility. The last time clients were served at the facility was May 16, 2022.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.<br><br>Interview on 05/18/22 the Licensee stated:<br>- There are no current clients at the facility.<br>- The was only one client recently at the facility and she was discharged to a state acute hospital setting on 05/16/22.<br>- She was aware to contact the Division of Health Service Regulation when clients were admitted to the facility. | V 000 | | |