

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL054-159</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MAPLEWOOD FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2002-G SHACKLEFORD ROAD KINSTON, NC 28502</b>
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(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
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on March 14, 2023. The complaint was substantiated (intake #' NC00199135). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment For Children and Adolescents.</p> <p>This facility is licensed for 18 and currently has a census of 17. The survey sample consisted of audits of 3 current client.</p>	V 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_