STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-746	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHEASTERN HEALTHCARE OF NORTH C/	3401 CARL SANDBURG COURT RALEIGH, NC 27620

(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 A complaint survey was completed on 11/22/23. The complaint was unsubstantiated (Intake # 00208347). No deficiencies were cited. The facility is licensed for the following service category 27G.1200 Psychosocial Rehabilitation facilities for individuals with severe and persistent mental illness. The facilty has a census of 63. The survey sample consisted of audits of 6 current clients.	V 000		