

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHH0976</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/21/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA DUNES BEHAVIORAL HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2050 MERCANTILE DRIVE LELAND, NC 28451</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>An annual and complaint survey was completed on August 21, 2024. One complaint was substantiated (intake #NC00219312) and 3 complaints were unsubstantiated (intakes #NC00219758, #NC00219756, and #NC00219622). 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 54 and currently has a census of 24. The survey sample consisted of audits of 3 current clients and 1 former client.</p>	V 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_