

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHH0976	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CAROLINA DUNES BEHAVIORAL HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 MERCANTILE DRIVE LELAND, NC 28451
---	--

(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	<p>INITIAL COMMENTS</p> <p>A limited follow up survey for the Type B was completed on October 2, 2024. This was a limited follow up survey, only 10A NCAC 27G .1901 Staff (V315) was reviewed for compliance. The following was brought back into compliance: 10A NCAC 27G .1901 Staff (V315). 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 13.</p>	V 000		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____