

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL065129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/31/2024
NAME OF PROVIDER OR SUPPLIER THE WAVE			STREET ADDRESS, CITY, STATE, ZIP CODE 3255 BURNT MILL DRIVE SUITE 5 WILMINGTON, NC 28403		
(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 complaint and follow up survey was completed on December 31, 2024. The complaint was unsubstantiated (intake #NC00224057). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .2300 Adult Developmental Vocational Programs for Individuals with Developmental Disabilities.</p> <p>This facility has a current census of 51. The survey sample consisted of audits of 6 current clients and 1 deceased client.</p>	V 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE