STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-269	A. BUILDING: _____ B. WING _____	R 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROJECT TRANSITION-WILMINGTON	**1514 DOCTOR'S CIRCLE WILMINGTON, NC 28401**

(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 and follow up survey was completed on January 10, 2025. The complaints were unsubstantiated (intake #NC00225074 and #NC00225229). No deficiencies were cited. This facility is licensed for the following service category: 10 A NCAC 27 G .1100 Partial Hospitalization for Individuals Who Are Acutely Mentally Ill. This facility has a current census of 31. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		