STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-122	A. BUILDING: _____ B. WING _____	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LCBHS-591 SILVER SPOON ROAD	591 SILVER SPOON ROAD EVERGREEN, NC 28438

(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 An annual survey was attempted on February 25, 2025. According to the Office Manager, there are no clients being served at the facility. The last time clients were served at the facility was 2/22/25. This facility is licensed for the following service categories: 10A NCAC 27G .5100 Community Respite Services for individuals of all Disability Groups (Residential) (Day). Interview on 2/25/25 the Office Manager stated the last client had been admitted on 2/4/25 and discharged on 2/22/25.	V 000		