STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL007-091	A. BUILDING: _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERSEALS PORT HEALTH-RAY G SILVER	1379 COWELL FARM ROAD WASHINGTON, NC 27889

(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 and complaint survey was completed on April 15, 2025. The complaint was unsubstantiated (intake #NC00228727). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of All Disability Groups and 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program (SAIOP). The facility has a current census of 5. The .5000 Facility Based Crisis Service for Individuals of All Disability Groups has a current census of 5 and the .4400 SAIOP has a current census of 0. The survey sample consisted of audits of 3 current Facility Based Crisis Service for Individuals of All Disability Groups clients.	V 000		