STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-185	A. BUILDING: _____ B. WING _____	C 06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEIC HOKE	400 WEST 8TH AVENUE RAEFORD, NC 28376

(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 survey was completed on June 24, 2025. The complaint was unsubstantiated (intake #NC00230964). No deficencies were cited. This facility is licensed for the following service category: 10A NCAC 27 .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 3 current clients and 1 former client.	V 000		