STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL052-012	A. BUILDING: _____ B. WING _____	R 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY-CARE BEHAVIORAL HEALTH II	301 FOURTH STREET MAYSVILLE, NC 28555

(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 follow up survey was attempted on July 22, 2025. According to the Licensee, there are no clients being served at the facility. The last time clients were served at the facility was around 5/22/25. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. Interview on 7/22/25 with the Director revealed: -There were no clients at the facility. -The last time a client was served was about two months ago. -Last client served used to be from sister facility. -She had being moved in to this facility in order to keep the staff employed. -Client was not very happy to be at the facility. -Client was moved back to sister facility about two months ago. -A new client was scheduled to move in either this week or the following. -She would inform the Division of Health Services and Regulation once the client started in order for annual survey to be conducted.	V 000		