

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL078-111</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/14/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE COURT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3750 MEADOW VIEW ROAD, APT A-1/DAY</b> <b>LUMBERTON, NC 28358</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on July 14, 2025. The complaint was unsubstantiated (Intake #NC00230933). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program and 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment.</p> <p>This facility has a current census of 8. The survey sample consisted of audits of 1 former client.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE