

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL024-118	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2025
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NAME OF PROVIDER OR SUPPLIER LCBHS-STANLEY CIRCLE	STREET ADDRESS, CITY, STATE, ZIP CODE 394 STANLEY CIRCLE WHITEVILLE, NC 28472
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(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>INITIAL COMMENTS</p> <p>An annual survey was completed on September 3, 2025. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services for Individuals of all Disability Groups (Residential).</p> <p>The facility is licensed for 2 and has a current census of 1. The survey sample consisted of 1 current client.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____