

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL024-011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2025
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NAME OF PROVIDER OR SUPPLIER WHITEVILLE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 168 SWEET FARM ROAD 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>A complaint survey was completed on October 31, 2025. The complaints were unsubstantiated (intakes #NC00234131 and #NC00234132). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .5100 Community Respite Services for Individuals of All Disability Groups and 10 A NCAC 27G .5600 Supervised Living for Adults with Mental Illness.</p> <p>The facility is licensed for 6 and currently has a census of 5. The survey sample consisted of 2 current clients.</p> <p>*Not enough time had passed to gain the documentation necessary for a follow up survey.</p>	V 000		

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