

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL074-239	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2025
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NAME OF PROVIDER OR SUPPLIER MEADOWBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 MEADOWBROOK DRIVE GREENVILLE, NC 27834
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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 and follow up survey was completed on November 14, 2025. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability and 10A NCAC 27G. 5100 Community Respite Services for Individuals of all Disability Groups.</p> <p>This facility is licensed for 3 and has a current census of 2. The .5100 Community Respite Services for Individuals of all Disability Groups program has a current census of 0 and the .5600C Supervised Living for Adults with Developmental Disability program has a current census of 2. The survey sample consisted of audits of 1 former client in the .5100 Community Respite Service for Individuals of all Disability Groups and 2 current clients in the .5600C SUPervised Living for Adults with Developmental Disability program.</p>	V 000		

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