

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL047-170	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2025
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NAME OF PROVIDER OR SUPPLIER SHARON LEAK AFL	STREET ADDRESS, CITY, STATE, ZIP CODE 255 CASTLE CREEKS DRIVE RAEFORD, NC 28376
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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 December 16, 2025. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G Supervised Living for Alternative Family Living.</p> <p>This facility is licensed for 1 and has a current census of 1. The survey sample consisted of audits of 1 client.</p>	V 000		

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