

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES  
CORRECTIVE ACTION PLAN**

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License #: **2172-14-001**

Organization Name: **Kempsville Center for Behavioral Health**

Date of Inspection: **10-05-2021**

Program Type/Facility Name: **14-001 The Kempsville Center for B.H.**

**No Violation**

**General Comments / Recommendations:**

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

\_\_\_\_\_  
Stella Stith

\_\_\_\_\_  
(Signature of Organization Representative)

\_\_\_\_\_  
Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined