

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2018
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INSIGHT HUMAN SERVICES - FORSYTH	STREET ADDRESS, CITY, STATE, ZIP CODE 665 WEST FOURTH STREET WINSTON SALEM, NC 27101
---	--

(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 12/6/18. (Intake # NC00139148 & NC00145597). The complaint was unsubstantiated . No deficiencies were cited.</p> <p>Current Census: 328</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .3300 Outpatient Detoxification for Substance Abuse; 10A NCAC 27G .3600 Outpatient Opioid Treatment; 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program; and 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program.</p>	V 000		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____