

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-982	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/09/2019
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NAME OF PROVIDER OR SUPPLIER CASCADE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 7108 WALLACE ROAD, APT 7000-A CHARLOTTE, NC 28212
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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 and follow up survey was completed on January 9, 2018. The complaint was unsubstantiated (Intake # NC00146654). No deficiencies were cited.</p> <p>The facility is licensed for the following service category: 10A NCAC 27G .4100 Residential Recovery Program for Individuals with Substance Abuse Disorders and their Children.</p>	V 000		

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