

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL007-081</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/03/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PORT HEALTH SERVICES - RAY G SILVERTHC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1379 COWELL FARM ROAD WASHINGTON, NC 27889</b>
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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><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on April 3, 2019. The complaint was unsubstantiated (intake #NC00149537). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program and 10A NCAC 27G .5000 Facility Based Crisis Services for Individuals of All Disability Groups.</p>	V 000		

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