

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL054-152</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/10/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIFE TOUCH, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>702 COLLEGE STREET KINSTON, NC 28501</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 March 10, 2020. The complaint was unsubstantiated (intake # NC00160669). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .1200 Psychosocial Rehabilitation Facilities for Individuals with Severe and Persistent Mental Illness, 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
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