

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL044-068</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/23/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE BALSAM CENTER ADULT RECOVERY UNIT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>91 TIMBERLANE ROAD WAYNESVILLE, NC 28786</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>An Annual and Complaint survey was completed April 23, 2021. The complaint was unsubstantiated (Intake NC 00174086). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of all Disability Groups.</p>	V 000		

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