

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/16/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ADDICTION RECOVERY CARE ASSOCIATION (</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1931 UNION CROSS ROAD WINSTON-SALEM, NC 27107</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 survey was completed on 3/16/22. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories:            10A NCAC 27G .3100 Non-hospital Medical Detoxification;            10A NCAC 27G .3400 Residential Treatment/Rehabilitation;            10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program;            10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment and            10A NCAC 27G .5000 Facility Crisis Services for All Disability Groups</p> <p>This facility is licensed for 67 and currently has a census of 32. The survey sample consisted of audits of 4 current clients.</p>	V 000		

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