

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL035-056</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/09/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VISIONS BEHAVIORAL HEALTH SERVICES, LL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>104 NORTH MAIN STREET, SUITE 200 LOUISBURG, NC 27549</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 6/9/22. The complaint was unsubstantiated Intake #NC00188792. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program &amp; 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program.</p> <p>This facility has a current census of 15. The survey sample consisted of audits of 2 current clients and 1 former client.</p>	V 000		

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