

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL019-065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2022
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NAME OF PROVIDER OR SUPPLIER CHATHAM RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 1758 E 11TH STREET, SUITE E SILER CITY, NC 27344
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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>INITIAL COMMENTS</p> <p>A complaint survey was completed on June 13, 2022. The complaint (intake #NC00188351) was unsubstantiated. No deficiencies cited.</p> <p>This facility is licensed for the following service categories: -10A NCAC 27G .3600 Outpatient Opioid Treatment</p> <p>The facility has a current census of 185. The survey sample consisted of audit of 1 deceased client.</p>	V 000		

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