STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-186	A. BUILDING: _____ B. WING _____	C 02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTORATION FAMILY SERVICES, INC	712 WILKINS STREET, UNIT D SMITHFIELD, NC 27577

(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	INITIAL COMMENTS A complaint survey was completed on 2/14/23. The complaint was unsubstantiated (intake #NC 00196566). No deficiencies were cited. This facility is licensed for the following category: 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program (SAIOP). This facility has a current census of 35. The survey sample consisted of audits of 1 former client.	V 000		