

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-003 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/29/2023 |
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| NAME OF PROVIDER OR SUPPLIER INSIGHT HUMAN SERVICES - FORSYTH | STREET ADDRESS, CITY, STATE, ZIP CODE 665 WEST FOURTH STREET WINSTON SALEM, NC 27101 |
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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 |
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| V 000 | <p>INITIAL COMMENTS</p> <p>A complaint survey was completed on 6/29/23. The complaint was unsubstantiated (intake # NC00202786). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .3300 Outpatient Detoxification for Substance Abuse 10A NCAC 27G .3600 Outpatient Opioid Treatment 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program (SAIOP) and 10A 27G .4500 Substance Abuse Comprehensive Outpatient (SACOT)</p> <p>This facility has a current census of 292. The survey sample consisted of an audit of 1 deceased client.</p> | V 000 | | |

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