

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-872	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/24/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARING SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 102/104 CHESTNUT STREET HIGH POINT, NC 27262
---	--

(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 July 24, 2023. The complaint was unsubstantiated (Intake #NC00203670). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program (SAIOP).</p> <p>This facility is licensed for 0 and currently has a census of 20. The survey sample consisted of audits of 1 former client.</p>	V 000		

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