Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		, , ,	(X3) DATE SURVEY COMPLETED	
MHL0601300		B. WING			7/23/2024			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ANUVIA P	REVENTION AND RECO	VERY CENTER	429 BILLIN	GSLEY ROAD				
			CHARLOT	TE, NC 28211				
(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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS			V 000				
	on 7-23-24. The com (intake #NC0021730-1730-1730-1730-1730-1730-1730-1730-	laint survey was completed plaint was unsubstantiful. A deficiency was cited for the following server. C 27G .3200 Social Sebstance Abuse, 10A Neal Treatment /Rehabilities. Substance Abuse Disorders of 39. The Detoxification) has a complete consumer of 1 sed Living For Adults Well and the pendency) has a currency sample consisted coical Setting Detoxification and 1 seatment /Rehabilitations tance Abuse Disorders of the pendency of the pendenc	iated ited. ice etting CAC ation rders, ing ncy. e current nent ice 1. Vith int I of icion					
		Supervised Living For a se Dependency client.	Adults					
V 118	27G .0209 (C) Medic	ation Requirements		V 118				
	only be administered order of a person aut drugs. (2) Medications shall		en cribe y					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL0601300		B. WING		0	7/23/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANUVIA P	REVENTION AND RECO	VERY CENTER		GSLEY ROAD E, NC 28211			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118			y nurse, and ations. AR) of e kept The  and the  or MAR	V 118			
	facility failed to ensur administered on the v	ews and interviews, the	cian,				
	-Date of admission: 6 -Date of discharge: 7	-					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL0601300		B. WING		07/2	3/2024	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ANUVIA P	REVENTION AND RECO	VERY CENTER		GSLEY ROAD TE, NC 28211				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	N SHOULD BE COMPLETI E APPROPRIATE DATE		
V 118	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 118					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
МН		MHL0601300	B. WING		07/23/2024		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
ANUVIA P	REVENTION AND RECO	VERY CENTER	GSLEY ROAD TE, NC 28211				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 118	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 118				

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