

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL051-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RHCC CAMBRIDGE PLACE CASAWORKS & PI	STREET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE PLACE - VARIOUS SUITES 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	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on 9/11/24. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .4100 Residential Recovery Programs for Individuals with Substance Abuse Disorders and Their Children.</p> <p>This facility is licensed for 13 and has a current census of 10. The survey sample consisted of audits of 4 current clients.</p>	V 000		

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