

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl064-074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 03/25/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA BLUE WATERS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>130 JONES ROAD ROCKY MOUNT, NC 27804</b>		
(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><b>INITIAL COMMENTS</b></p> <p>A complaint and survey was completed on 3/25/25. The complaint was unsubstantiated (Intake #NC 00226771). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1200 Psychosocial Rehabilitation Facilities for Individuals with Severe and Persistent Mental Illness.</p> <p>The facility had a census of 33 clients and the survey sample consisted of audits of 1 current client.</p>	V 000		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE