

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL032-390</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/08/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY CHOICES, INC - CASCADE @ DU</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2309 NATION AVENUE, APT. #15 DURHAM, NC 27707</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 survey was completed on 5/8/25. Complaint intake #NC00228901 was unsubstantiated. Complaint intake #NC00229560 was substantiated. 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>The facility is licensed for 14 and currently has a census of 8. The survey sample consisted of audits of 3 current clients.</p>	V 000		

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

TITLE

(X6) DATE