

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL014-085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2019
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NAME OF PROVIDER OR SUPPLIER HORIZONS DAY TREATMENT	STREET ADDRESS, CITY, STATE, ZIP CODE 332 GREENHAVEN DRIVE NW, A WING & ROOM #20 LENOIR, NC 28645
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(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 complaint survey was completed on 2/19/19. The complaint was unsubstantiated (NC00147488). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1400 Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbance.</p>	V 000		

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