

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2019
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NAME OF PROVIDER OR SUPPLIER FREEDOM	STREET ADDRESS, CITY, STATE, ZIP CODE 1089 X RAY DRIVE GASTONIA, NC 28054
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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>A complaint survey was completed on September 23, 2019. The complaint was unsubstantiated (Intake #NC 00155230). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .3100 Nonhospital Medical Detoxification for Individuals who are Substance Abusers and 10A NCAC 27G .3300 Outpatient Detoxification for Substance Abuse.</p>	V 000		

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