

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL002-029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2019
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NAME OF PROVIDER OR SUPPLIER ADDICTION RECOVERY MEDICAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 31 E MAIN AVENUE TAYLORSVILLE, NC 28681
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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 survey was completed on 11/20/2019. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .3300 Outpatient Detoxification for Substance Abuse 10A NCAC 27G .3600 Outpatient Opioid Treatment</p> <p>The current census was 251.</p>	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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