

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2020
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NAME OF PROVIDER OR SUPPLIER MCLEOD ADDICTIVE DISEASE CENTER - 1ST FLOOR	STREET ADDRESS, CITY, STATE, ZIP CODE 515 CLANTON ROAD, 1ST FLOOR CHARLOTTE, NC 28217
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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 7/23/20. The complaints were unsubstantiated(Intakes #166956, #166960). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program and 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program.</p>	V 000		

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