

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL047-131</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HOPE GARDENS TREATMENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1958 TURNPIKE ROAD</b> <b>RAEFORD, NC 28376</b>
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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><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on October 7, 2020. The complaint was unsubstantiated (intake #NC169948). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.</p>	V 000		

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