

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL098-207	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2021
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NAME OF PROVIDER OR SUPPLIER DIXON SOCIAL INTERACTIVE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1812-A GLENDALE DRIVE, SW WILSON, NC 27894
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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 January 27, 2021. The complaint was unsubstantiated Intake #NC00172266. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program.</p>	V 000		

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