

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL049-122</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/16/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ARMS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>536 SIGNAL HILL DRIVE EXTENSION STATESVILLE, NC 28625</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>An annual survey was completed on July 16, 2021. No deficiencies were cited.</p> <p>This facility is licensed for the following service category:</p> <ul style="list-style-type: none"> <li>- 10A NCAC 27G .3300: Outpatient Detox</li> <li>- 10A NCAC 27G .3600: Outpatient Opioid Treatment</li> <li>- 10A NCAC 27G .4400: Substance Abuse Intensive Outpatient Program</li> </ul> <p>The census as of July 16, 2021 was:</p> <ul style="list-style-type: none"> <li>- 0 Outpatient Detox</li> <li>- 486 in the Outpatient Opioid Treatment</li> <li>- 0 in the Substance Abuse Intensive Outpatient Program</li> </ul>	V 000		

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