

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-962	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/19/2022
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NAME OF PROVIDER OR SUPPLIER METRO TREATMENT OF NC, LP DBA NEW SE/	STREET ADDRESS, CITY, STATE, ZIP CODE 3911 NEW BERN AVENUE, UNIT A RALEIGH, NC 27610
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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
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{V 000}	<p>INITIAL COMMENTS</p> <p>A follow up survey was completed on December 19, 2022. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment.</p> <p>This facility has a current census of 89. The survey sample consisted of audits of 8 current clients.</p>	{V 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____