Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-272	A. BUILDING: _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCTOBER ROAD, INC	119 TUNNEL ROAD, SUITE B ASHEVILLE, NC 28805

(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	INITIAL COMMENTS A complaint survey was completed on 11/20/23. The complaint was unsubstantiated (Intake# NC00209193). No deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Opioid Treatment, 10A NCAC 27G .3700 Day Treatment Facilities for Individuals with Substance Abuse Disorders, 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program, 10A NCAC 27G. 4500 Substance Abuse Comprehensive Outpatient Treatment Program. This facility has a current census of 236 in the 3600 program, 0 in the 3700, 53 in the 4400 program and 36 in the 4500 program. The survey sample consisted of an audit of 1 current client.	V 000		

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