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
	MHL036-332	A. BUILDING: _____ B. WING _____	R 07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEDOM	1089 X RAY DRIVE GASTONIA, NC 28054

(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 limited follow up survey for the Type A2 was completed on 7-19-24. This was a limited follow up survey and only 10A NCAC 27G .0304 Facility Design and Equipment (V752) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0304 Facility Design and Equipment (V752). This facility is licensed for 30 and currently has a census of 25. The 10A NCAC 27G .3100 Nonhospital Medical Detoxification for Individuals Who are Substance Abusers has a current census of 18 and the NCAC 27G .3400 Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders has a current census on 7.	V 000		

Division of Health Service Regulation

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