STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-089	A. BUILDING: _____ B. WING _____	R 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOOTHILLS REGIONAL TREATMENT CENTER	2415 MORGANTON BOULEVARD, SUITE 200 LENOIR, NC 28645

(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 An annual and follow up survey was completed on 4/3/25. No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of All Disability Groups. The facility is licensed for 12 and has a current census of 9. The survey sample consisted of an audit of 3 current clients.	V 000		