STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-126	A. BUILDING: _____ B. WING _____	C 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD TREATMENT CENTER	2002 A, B, D, E & G SHACKLEFORD ROAD KINSTON, NC 28504

(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 July 8, 2025. Six complaints were substaniated (intake #'s NC00232260, NC00232200, NC00232163, NC00231881, NC00231892 and NC00231889) and two complaints were unsubstantiated (intake #'s NC00232259 and NC00231419). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC .1900 Psychiatric Residential Treatment for Children and Adolescents. This facility is licensed for 42 and has a current census of 42. The survey sample consisted of audits of 10 current clients and 1 former client.	V 000		