

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-126	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2025
NAME OF PROVIDER OR SUPPLIER OAKWOOD TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on July 30, 2025. Five complaints were substantiated (intake #'s NC00232343, NC00232351, NC00232688, NC00232690 and NC00232709) and one complaint was unsubstantiated (intake # NC00232616). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC .1900 Psychiatric Residential Treatment for Children and Adolescents.</p> <p>This facility is licensed for 41 and has a current census of 42. The survey sample consisted of audits of 7 current clients.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE