

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/19/2025
NAME OF PROVIDER OR SUPPLIER MCLEOD CENTERS FOR WELLBEING			STREET ADDRESS, CITY, STATE, ZIP CODE 117 WEST MEDICAL COURT MARION, NC 28752		
(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>An annual and follow up survey was completed on August 19, 2025. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Opioid Treatment.</p> <p>This facility has a current census of 351. The survey sample consisted of audits of 16 current clients.</p>	V 000			

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

TITLE

(X6) DATE