STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY ETED		
		MHL063-100		B. WING		08/19/2025	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
IVCKSUM	SPRINGS TREATMENT	CENTED	778 HOFF	IAN ROAD			
JACKSON	SPRINGS TREATMENT	CENTER	WEST END	, NC 27376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS			V 000			
	An annual and complaint survey was completed on August 19, 2025. The complaint was unsubstantiated (intake #NC00233025). Deficiencies were cited.						
		d for the following serv 27G .1900 Psychiatric t for Children and					
		d for 12 and has a curr vey sample consisted ents.					
V 132	G.S. 131E-256(G) HC Allegations, & Protect			V 132			
	G.S. §131E-256 HEA REGISTRY	LTH CARE PERSONN	IEL				
	Department is notified health care personne unknown source, which	es shall ensure that the dof all allegations againd including injuries of the appear to be related ivision (a)(1) of this sections.	nst I to				
	facility or a person to as defined by G.S. 13	of a resident in a healt whom home care serv de-136 or hospice ser de-201 are being prov	ices vices				
	b. Misappropriation of in a health care facilit(b) of this section includer care services as defined	of the property of a res y, as defined in subsectuding places where ho ned by G.S. 131E-136 (ident ction me or				
	are being provided. c. Misappropriation of healthcare facility.	s belonging to a health					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		i i	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL063-100	B. WING	 	08	3/19/2025
NAME OF P	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATE	E, ZIP CODE		
JACKSON	N SPRINGS TREATMENT	CENTER	FFMAN ROAD END, NC 27376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 132	e. Fraud against a ha patient or client for providing services). Facilities must have acts are investigated to protect residents frinvestigation is in proinvestigations must b Department within fivnotification to the Department of First Registry (HCPR) was abuse against the First Residential Mentors. Review on 8/13/25 of Department of Admission: 90 Department of Admission: 91 Department of Admission: 92 Department of Admission: 93 Department of Admission: 93 Department of Admission: 93 Department of Admission: 93 Department of Admission: 94 Diagnoses: Disruptiv Disorder, Attention Decombined presentation Adolescent type, mod Schizophrenia Spectro Disorder.	ealth care facility or against whom the employee is evidence that all alleged and must make every effort om harm while the gress. The results of all e reported to the e working days of the initial partment. as evidenced by: ew and interviews the facility ealth Care Personnel ontified of an allegation of st Responder and The findings are: Client #1's record revealed: 1/3/24 ent Disorder with mixed ens and conduct, Attention Disorder, predominantly positional Defiant Disorder, ied, Disruptive mood er, Parent-biological child umatic Stress Disorder. Client #2's record revealed: 1/4/25 e Mood Dysregulation efficit Hyperactivity Disorder, on severe, Conduct Disorder lerate, and Other Specified rum and Other Psychotic Client #3's record revealed: 0/25/24	V 132			

Division of Health Service Regulation

STATE FORM 6899 UQ7V11 If continuation sheet 2 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL063-100	B. WING		00	3/19/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
JACKSON	N SPRINGS TREATMENT	CENTER	FFMAN ROAD END, NC 27376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 132	Attention Deficit Hypunspecified type, Autoriol Intellectual Unspecified Anxiety Review on 8/14/25 or revealed: -No documentation of First Responder, Exestaff #4, and Staff #5 abusing client #1 on physically abusing client #1 on physically abusing client #1 on the First Responder, Staff #4, and Staff #5 abusing client #1 on physically abusing clien	eractivity Disorder, tism spectrum disorder, al functioning, and Disorder (by history). If the facility's records If HCPR notification for the ecutive Director, Staff #3, If physically and verbally 8/8/25 and Staff #5 ient #2 on 8/10/25. If the North Carolina Incident ent System (IRIS) revealed: If submission of a report for Executive Director, Staff #3, If physically and verbally 8/8/25 and Staff #5 ient #2 on 8/10/25. and 8/18/25 with the evealed: Ident report and sent e President." I is the person that eport and reports the If told me that she would mation for the IRIS report,	V 132			

Division of Health Service Regulation

STATE FORM 6899 UQ7V11 If continuation sheet 3 of 12

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL063-100	MHL063-100 B. WING		08/19/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
JACKSON	I SPRINGS TREATMENT	CENTER 778 HOFFN WEST END	IAN ROAD , NC 27376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPI	LETE
V 366	Continued From page	: 3	V 366			
V 366	27G .0603 Incident Response Requirements		V 366			
	implement written pol response to level I, II shall require the provi (1) attending to of individuals involved (2) determining (3) developing a measures according to timeframes not to except (4) developing a to prevent similar incises pecified timeframes (5) assigning post for implementation of preventive measures; (6) adhering to set forth in G.S. 75, A 42 CFR Parts 2 and 3 164; and (7) maintaining Subparagraphs (a)(1) (b) In addition to the Paragraph (a) of this shall address incident regulations in 42 CFR (c) In addition to the Paragraph (a) of this shall address incident regulations in 42 CFR (c) In addition to the Paragraph (a) of this shall address incident regulations in 42 CFR (c) In addition to the Paragraph (a) of this shall address incident regulations in 42 CFR (c) In addition to the Paragraph (a) of this shall address incident regulations in 42 CFR (c) In addition to the Paragraph (a) of this shall evelop and implement their response to a lew while the provider is con while the client is or while the clien	REMENTS FOR PROVIDERS providers shall develop and dicies governing their or III incidents. The policies der to respond by: the health and safety needs I in the incident; the cause of the incident; and implementing corrective or provider specified eed 45 days; and implementing measures dents according to provider not to exceed 45 days; erson(s) to be responsible the corrections and confidentiality requirements ricicle 2A, 10A NCAC 26B, and 45 CFR Parts 160 and documentation regarding through (a)(6) of this Rule. requirements set forth in Rule, ICF/MR providers is as required by the federal				

Division of Health Service Regulation

STATE FORM 6899 UQ7V11 If continuation sheet 4 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED
		MHL063-100	B. WING	B. WING		/19/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		778 HOF	FMAN ROAD			
JACKSON	I SPRINGS TREATMENT	CENTER WEST EN	ID, NC 27376			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF	CORRECTION	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACT		(X5) COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO 1		DATE
				DEFICIENC	JY)	
V 366	Continued From page	e 4	V 366			
	L					
	by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and					
		the copy to an internal				
review team;						
		a meeting of an internal				
		4 hours of the incident. The				
		shall consist of individuals				
	who were not involved in the incident and who					
	were not responsible	for the client's direct care or				
		al oversight of the client's				
	services at the time of	of the incident. The internal				
	review team shall cor	nplete all of the activities as				
	follows:					
	(A) review the c	copy of the client record to				
		nd causes of the incident				
		dations for minimizing the				
	occurrence of future i					
		er information needed;				
		en preliminary findings of fact				
	_	ays of the incident. The				
	i	of fact shall be sent to the				
		nent area the provider is				
	if different; and	ME where the client resides,				
	· ·	I written report signed by the				
	, ,	onths of the incident. The				
		ent to the LME in whose				
	•	rovider is located and to the				
		resides, if different. The				
		all address the issues				
	· ·	nal review team, shall				
	_	uments pertinent to the				
	-	ake recommendations for				
	· ·	rence of future incidents. If				
	_	d for the report are not				
		•				

Division of Health Service Regulation

STATE FORM 6899 UQ7V11 If continuation sheet 5 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	MHL063-100 B. WING				08	3/19/2025
	ROVIDER OR SUPPLIER	CENTER 778 HOFF	DRESS, CITY, STA MAN ROAD D, NC 27376	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 366	LME may give the pro- three months to subm (3) immediately (A) the LME res area where the service Rule .0604; (B) the LME wh different; (C) the provider for maintaining and up treatment plan, if differ provider; (D) the Departm (E) the client's l applicable; and	months of the incident, the ovider an extension of up to lit the final report; and into notifying the following: ponsible for the catchment les are provided pursuant to litere the client resides, if agency with responsibility odating the client's rent from the reporting	V 366			
	facility failed to impler response to Level II in findings are: Review on 8/13/25 of -Date of Admission: 9 -Diagnoses: Adjustme disturbance of emotio Deficit Hyperactivity E hyperactive type, Opp Depression, unspecific dysregulation disorde	ew and interviews, the ment a policy governing their ncidents as required. The Client #1's record revealed: //3/24 ent Disorder with mixed ns and conduct, Attention Disorder, predominantly positional Defiant Disorder,				

Division of Health Service Regulation

STATE FORM 6899 UQ7V11 If continuation sheet 6 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL063-100	B. WING	B. WING		08/19/2025	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	1 00	71372023	
IVCKSON	I SPRINGS TREATMENT	CENTER 778 HOFF	MAN ROAD				
JACKSON	SPRINGS TREATMENT	WEST EN	ID, NC 27376				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 366	Continued From page	e 6	V 366				
	-Date of Admission: 4 -Diagnoses: Disruptiv Disorder, Attention Di combined presentation Adolescent type, mod Schizophrenia Spectra Disorder.	ve Mood Dysregulation eficit Hyperactivity Disorder, on severe, Conduct Disorder derate, and Other Specified rum and Other Psychotic					
	Review on 8/13/25 of Client #3's record revealed: -Date of Admission: 10/25/24 -Diagnoses: Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, unspecified type, Autism spectrum disorder, Borderline Intellectual functioning, and Unspecified Anxiety Disorder (by history). Review on 8/14/25 of the North Carolina (NC)						
	Incident Response In revealed: -No documentation of the First Responder, Staff #4, and Staff #5 abusing client #1 on 8 physically abusing cli-There was no docum cause of the incident; implemented correction the provider specified 45 days; no measure according to provider exceed 45 days and a specified with the provider specified 45 days; no measure according to provider exceed 45 days and a specified with the provider specified 45 days and a specified with the provider spec	f submission of a report for Executive Director, Staff #3, physically and verbally 8/8/25 and Staff #5 ent #2 on 8/10/25. Thentation to determine: The staff the facility developed and the reasures according to a timeframes not to exceed a to prevent similar incidents a specified timeframes not to assigning person(s) to be mentation of the corrections					
	Interview on 8/13/25 revealed: -"I completed the inci everything to the Vice-The IVice President!	President."					

Division of Health Service Regulation

STATE FORM 6899 UQ7V11 If continuation sheet 7 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL063-100	B. WING		08/19/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREE	TADDRESS, CITY, STA	TE, ZIP CODE		
JACKSON	I SPRINGS TREATMENT	CENTER 778 H	OFFMAN ROAD			
		WEST	END, NC 27376			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE	
V 366	Continued From page	· 7	V 366			
	completes the IRIS reallegations to HCPR." -"The [Vice President] conducting an internal -"The [Vice President] send me all the inform the report to HCPR, a investigation." -"I have not received a [Vice President]."	port and reports the I told me that she will be I investigation, not me." I told me that she would nation for the IRIS report, nd the internal any paperwork from the cility failed to implement a				
V 367	27G .0604 Incident Re	eporting Requirements	V 367			
	V 367 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident;					

Division of Health Service Regulation

STATE FORM 6899 UQ7V11 If continuation sheet 8 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		
		MHL063-100	B. WING		08/19/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	JE ZIP CODE	•	
TO WILL OF T	NOVIDER OR GOLF EIER		MAN ROAD			
JACKSON	I SPRINGS TREATMENT	CENTER	D, NC 27376			
			D, NC 2/3/6			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
V 367	Continued From page	e 8	V 367			
V 367	cause of the incident; (6) other individes or responding. (b) Category A and B missing or incomplete shall submit an update report recipients by the day whenever: (1) the provider information provided information provided erroneous, misleading (2) the provider required on the incided unavailable. (c) Category A and B upon request by the L obtained regarding the (1) hospital recipinformation; (2) reports by conformation; (3) the provider (d) Category A and B of all level III incident Mental Health, Develor Substance Abuse Serbecoming aware of the providers shall send a incidents involving a conformation; aware of the client death within service Regul becoming aware of the client death within service restraint, the provider or restraint or	e effort to determine the and duals or authorities notified B providers shall explain any e information. The provider red report to all required ne end of the next business or has reason to believe that in the report may be gor otherwise unreliable; or robtains information ent form that was previously B providers shall submit, LME, other information including: ords including confidential other authorities; and r's response to the incident. B providers shall send a copy reports to the Division of opmental Disabilities and rvices within 72 hours of the incident. Category A a copy of all level III client death to the Division of ation within 72 hours of the incident. In cases of the incident. In cases of the incident. In cases of the shall report the death fired by 10A NCAC 26C control 27E .0104(e)(18). B providers shall send a telement of the incident at the case of the c	V 367			
		e services are provided. ubmitted on a form provided				

Division of Health Service Regulation

STATE FORM 6899 UQ7V11 If continuation sheet 9 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			
		MHL063-100	B. WING	08	08/19/2025	
	PROVIDER OR SUPPLIER	CENTER 778 HOF	DDRESS, CITY, STATE FMAN ROAD ID, NC 27376	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 367	by the Secretary via e include summary info (1) medication definition of a level II (2) restrictive in the definition of a level (3) searches of (4) seizures of the possession of a c (5) the total nui incidents that occurre (6) a statement been no reportable in incidents have occurr meet any of the criter	electronic means and shall rmation as follows: errors that do not meet the or level III incident; atterventions that do not meet tel II or level III incident; a client or his living area; client property or property in lient; mber of level II and level III ad; and a indicating that there have cidents whenever no ed during the quarter that ia as set forth in Paragraphs e and Subparagraphs (1)	V 367			
	facility failed to ensur to the Local Manager Organization (LME/M where services are proposed on the Review on 8/13/25 of -Date of Admission: 9 -Diagnoses: Adjustment disturbance of emotion Deficit Hyperactivity I	ew and interviews, the e an incident was reported ment Entity/Managed Care CO) for the catchment area rovided within 72 hours of the incident. The findings are: Client #1's record revealed: 1/3/24 ent Disorder with mixed the and conduct, Attention Disorder, predominantly the positional Defiant Disorder,				

Division of Health Service Regulation

STATE FORM 6899 UQ7V11 If continuation sheet 10 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
		MHL063-100	B. WING	B. WING		3/19/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	E, ZIP CODE		
JACKSON	N SPRINGS TREATMENT	CENTER 778 HOFF	MAN ROAD			
		WEST EN	ID, NC 27376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
V 367	Continued From page 10 dysregulation disorder, Parent-biological child conflict, and Post Traumatic Stress Disorder.		V 367			
	-Date of Admission: 4 -Diagnoses: Disruptiv Disorder, Attention Do combined presentation Adolescent type, mod	Client #2's record revealed: /4/25 re Mood Dysregulation reficit Hyperactivity Disorder, reficit Severe, Conduct Disorder reflerate, and Other Specified rum and Other Psychotic				
	Review on 8/13/25 of Client #3's record revealed: -Date of Admission: 10/25/24 -Diagnoses: Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, unspecified type, Autism spectrum disorder, Borderline Intellectual functioning, and Unspecified Anxiety Disorder (by history).					
	Incident Response Imrevealed: -No documentation of the First Responder,					
	conducting an interna	vealed: dent report and sent President." is the person that port and reports the				

Division of Health Service Regulation

STATE FORM 6899 UQ7V11 If continuation sheet 11 of 12

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER JACKSON SPRINGS TREATMENT CENTER (X4) ID PREFIX TAG (SACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG COntinued From page 11 the report to HCPR, and the internal investigation." "I have not received any paperwork from the [Vice President]." -She confirmed the facility failed to report the above incidents to LME/MCO within 72 hours.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED	
JACKSON SPRINGS TREATMENT CENTER T78 HOFFMAN ROAD WEST END, NC 27376 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 11 the report to HCPR, and the internal investigation." -"I have not received any paperwork from the [Vice President]." -She confirmed the facility failed to report the			MHL063-100	B. WING		08	/19/2025
JACKSON SPRINGS TREATMENT CENTER WEST END, NC 27376 (X4) ID PREFIX TAG PREFIX TAG Continued From page 11 the report to HCPR, and the internal investigation." -"I have not received any paperwork from the [Vice President]." -She confirmed the facility failed to report the	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 11 the report to HCPR, and the internal investigation." -"I have not received any paperwork from the [Vice President]." -She confirmed the facility failed to report the	JACKSON	I SPRINGS TREATMENT	CENTER				
the report to HCPR, and the internal investigation." -"I have not received any paperwork from the [Vice President]." -She confirmed the facility failed to report the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	COMPLETE
investigation." -"I have not received any paperwork from the [Vice President]." -She confirmed the facility failed to report the	V 367	Continued From page	e 11	V 367			
	V 36/	the report to HCPR, a investigation." -"I have not received [Vice President]." -She confirmed the fa	and the internal any paperwork from the acility failed to report the	V 30/			

Division of Health Service Regulation

STATE FORM 6899 UQ7V11 If continuation sheet 12 of 12