

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL044-062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/14/2025
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NAME OF PROVIDER OR SUPPLIER BHG CLYDE TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 HOSPITAL DRIVE CLYDE, NC 28721
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(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 10/14/25. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment and 10A NCAC 27G.4400 Substance Abuse Intensive Outpatient Program.</p> <p>The facility is licensed for 0 in the 3600 program and has a current census of 220. The 4400 program is licensed for 0 and has a census of 2. The survey sample consisted of audits of 10 current clients and 1 deceased client.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____