

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL078-344</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/04/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RON BARNES CENTER FOR RECOVERY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1165 WEST PARKTON TOBEMORY ROAD PARKTON, NC 28371</b>
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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><b>INITIAL COMMENTS</b></p> <p>Acomplaint survey was completed on November 4, 2025. The complaint was substantiated (intake #NC00234159). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency.</p> <p>This facility is licensed for 76 and has a current census of 74. The survey sample consisted of audits of 1 current client.</p>	V 000		

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