

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/16/2025
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NAME OF PROVIDER OR SUPPLIER JACKSONVILLE TREATMENT CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 291 HUFF DRIVE JACKSONVILLE, NC 28546
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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
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on December 16, 2025. The complaint was unsubstantiated (intake #NC00234382). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Opioid Treatment and 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program (SAIOP).</p> <p>This facility has a current census of 399. The .3600 Outpatient Opioid Treatment has a current census of 399 and the .4400 Substance Abuse Intensive Outpatient Program (SAIOP) has a current census of 0. The survey sample consisted of audits of 20 current clients in the Outpatient Opioid Treatment.</p>	V 000		
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Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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