

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL019-077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2025
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NAME OF PROVIDER OR SUPPLIER NORTH WIND RANCH	STREET ADDRESS, CITY, STATE, ZIP CODE 17880 US HIGHWAY 64 SILER CITY, NC 27344
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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>Annual and complaint survey was completed on December 16, 2025. The complaints were unsubstantiated (intake #NC00234569 and #NC00234955). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment Facilities for Children and Adolescents.</p> <p>This facility is licensed for six and has a current census of three. The survey sample consisted of audits of two current clients and one former client.</p>	V 000		

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