

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL049-101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/15/2026
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NAME OF PROVIDER OR SUPPLIER MCLEOD CENTERS FOR WELLBEING	STREET ADDRESS, CITY, STATE, ZIP CODE 636 SIGNAL HILL DRIVE. EXT. STATESVILLE, NC 28625
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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 4/15/2026. 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.</p> <p>The facility is licensed for 0 and currently has a census of 175. The 10A NCAC 27G .3600 Outpatient Opioid Treatment has a census of 175 and the 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program has a current census of 0. The survey sample consisted of audits of 9 current clients in the 10A NCAC 27G .3600 Outpatient Opioid Treatment.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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