STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL076-092	A. BUILDING: _____ B. WING _____	10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAYMARK RECOVERY SERVICES RANDOLPH	110 WEST WALKER AVE, SECOND FLLOR ASHEBORO, NC 27203

(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	INITIAL COMMENTS A complaint and annual survey was completed on 10/19/18. The complaint was unsubstantiated (Complaint Intake ID #NC00143469.) No deficiencies were cited. The facility is licensed for the following service categories: 10A NCAC 27G 3700 Day Treatment Facilities for Individuals with Substance Abuse Disorders 10A NCAC 27G 4400 Substance Abuse Intensive Outpatient Program 10A NCAC 27G 4500 Substance Abuse Comprehensive Outpatient Treatment Program.	V 000		

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