

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-870	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/22/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER UNC HEALTH CARE FACILITY BASED CRISIS AT WAH	STREET ADDRESS, CITY, STATE, ZIP CODE 107 SUNNYBROOK ROAD, SUITE A RALEIGH, NC 27610
---	--

(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>A complaint survey was completed on April 22, 2019. The complaints were unsubstantiated (NC#00147149 and NC00148850). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5000 Facility Based Crisis Service For Individuals of All Dissability Groups.</p>	V 000		

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