

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL011-421</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/14/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAIYALYNN BURRELL CHILD CRISIS CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>277 BILTMORE AVENUE ASHEVILLE, NC 28801</b>
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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><b>INITIAL COMMENTS</b></p> <p>A complaint survey was completed on November 14, 2019. The complaints were unsubstantiated (Intake# NC00156545 and NC00157292). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .3100 Nonhospital Medical Detoxification for Individuals who are Substance Abusers and 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of All Disability Groups.</p>	V 000		

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