

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-424	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2022
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NAME OF PROVIDER OR SUPPLIER CAIYALYNN BURRELL CHILD CRISIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 277 BILTMORE AVENUE ASHEVILLE, NC 28801
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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>A complaint survey was completed on 8/22/22. The complaint was unsubstantiated (Intake #NC190964). 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, 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of all Disability Groups</p> <p>This facility is licensed for 16 and currently has a census of 8. The survey sample consisted of audits of 3 current clients and 1 former client.</p>	V 000		

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