Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MHL077-088		B. WING		C 10/10/2022		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
CHILD FA	C BASED CRISIS OF RIC	CHMOND-DAYMARK	TH US HIGHWAY GHAM, NC 28379			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	10, 2022. The complation (intake #NC00193734) This facility is licensed category: 10A NCAC Crisis Service for India Groups. This facility is licensed census of 11. The sur	as completed on October aint was substantiated 4). A deficiency was cited. d for the following service 27G .5000 Facility Bases viduals of all Disability d for 16 and currently has a rvey sample consisted of ents and 1 former client.				
V 364	Facilities § 122C-62. Additional Facilities.	-	V 364			
	122C-51 through G.S who is receiving treat 24-hour facility keeps (1) Send and receive access to writing mate assistance when nece (2) Contact and consand at no cost to the physicians, and private developmental disabite professionals of his ce (3) Contact and consthere is a client advocation there is a client advocation to the rights specified in restricted by the facility exercise these rights (b) Except as provided of this section, each accept the section of the se	e sealed mail and have erial, postage, and staff essary; sult with, at his own expense facility, legal counsel, private te mental health, lities, or substance abuse hoice; and sult with a client advocate if cate. In this subsection may not be ty and each adult client may at all reasonable times. ed in subsections (e) and (h) adult client who is receiving on in a 24-hour facility at all				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

, ,		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING: _		COMPL	ETED	
		MHL077-088		B. WING		1	0/2022	
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADD	RESS, CITY, STA	TE. ZIP CODE			
523 NORTH US HIGHWAY 1, SUITE C								
CHILD FA	C BASED CRISIS OF RIC	CHMOND-DAYMARK		IAM, NC 2837				
(VA) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES		, 	PROVIDER'S PLAN OF CORRECTI		(VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE	
					DEFICIENCY)			
V 364	Continued From page	e 1		V 364				
	(1) Make and receiv	e confidential telephone						
	` ,	e calls shall be paid for by						
	_	of making the call or made						
	collect to the receivin	_						
		between the hours of 8:00						
	` '	or a period of at least six						
		s of which shall be after 6:0	0					
	•	g shall not take precedence						
	over therapies;							
	(3) Communicate ar	nd meet under appropriate						
	supervision with indiv	riduals of his own choice						
	upon the consent of t	he individuals;						
	(4) Make visits outsi	de the custody of the facility	y					
	unless:							
		ceedings were initiated as						
		t's being charged with a						
		ng a crime involving an						
	assault with a deadly							
		d not guilty by reason of						
	insanity or incapable							
		oluntarily admitted or						
	commitment to a corr	lity while under order of						
		ectional facility of the rection of the Department of	F					
	Public Safety; or	Socion of the Department of						
		ng held to determine capaci	tv					
	to proceed pursuant t		,					
		pressly authorize visits						
		by the existence of the						
	conditions prescribed							
		daily and have access to						
		ent for physical exercise						
	several times a week	•						
	` '	oited by law, keep and use						
		possessions, unless the						
	•	determine capacity to						
	proceed pursuant to							
	(7) Participate in reli							
	(8) Keep and spend	a reasonable sum of his						

Division of Health Service Regulation

STATE FORM 6899 6M3S11 If continuation sheet 2 of 7

Division of Health Service Regulation

	n rieaith Service Regu				T
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
					С
		MUI 077 000	B. WING		
		MHL077-088	1		10/10/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		523 NOR	TH US HIGHWAY	Y 1. SUITE C	
CHILD FA	C BASED CRISIS OF RIC	CHMOND-DAYMARK	SHAM, NC 2837	·	
	OUR MAR DV OT				.,
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
V 364	Continued From page		V 364		
V 304	Continued From page	9 2	V 304		
	own money;				
	(9) Retain a driver's	license, unless otherwise			
	prohibited by Chapter	20 of the General Statutes;			
	and	,			
	(10) Have access to in	ndividual storage space for			
	his private use.	3 1			
	-	rights enumerated in G.S.			
	122C-51 through G.S	•			
	•	. 122C-61, each minor client			
	•	ment or habilitation in a			
		e right to have access to			
	proper adult supervisi				
		or's status as a developing			
	individual, the minor s				
		le him to mature physically,			
	emotionally, intellectu				
	<u>-</u>	of the physical, emotional,			
		turity of the minor, the			
	24-hour facility shall p				
		and control consistent with			
		minor pursuant to this Part.			
		where practical, make ensure that each minor			
		ent apart and separate from the treatment needs of the			
	minor client dictate of				
		o is receiving treatment or			
		hour facility has the right to:			
		d consult with his parents or			
	-	cy or individual having legal			
	custody of him;	oult with at his own sweets			
		sult with, at his own expense			
		esponsible person and at no			
	cost to the facility, leg				
		ental health, developmental			
		nce abuse professionals, of			
		onsible person's choice; and			
	• •	sult with a client advocate, if			
	there is a client advocate.				

Division of Health Service Regulation

STATE FORM 6899 6M3S11 If continuation sheet 3 of 7

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					c	
		MHL077-088	B. WING		10/10/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE ZIP CODE		
	101.52.1 0.1 00.1 2.2.1		RTH US HIGHWA			
CHILD FA	C BASED CRISIS OF RIC	CHMOND-DAYMARK	IGHAM, NC 2837			
	OUR MAR DV OT					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD	(-/	
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		
				DEFICIENCY)		
V 364	Continued From page 3		V 364			
	The rights specified in	n this subsection may not be				
	• .	ity and each minor client				
		ights at all reasonable times.				
		led in subsections (e) and (h)				
		minor client who is receiving				
		on in a 24-hour facility has				
	the right to:	,				
	•	e telephone calls. All long				
		e paid for by the client at the				
	time of making the ca	all or made collect to the				
	receiving party;					
	(2) Send and receive	e mail and have access to				
	writing materials, pos	tage, and staff assistance				
	when necessary;					
	. ,	te supervision, receive				
		nours of 8:00 a.m. and 9:00				
		t least six hours daily, two				
		pe after 6:00 p.m.; however				
	_	precedence over school or				
	therapies;	education and vocational				
		e with federal and State law;				
	_	daily and participate in play,				
		cal exercise on a regular				
	basis in accordance v	_				
		oited by law, keep and use				
	personal clothing and					
	· -	on, unless the client is being				
		pacity to proceed pursuant to				
	G.S. 15A-1002;					
	(7) Participate in reli	igious worship;				
		ndividual storage space for				
	the safekeeping of pe					
	` '	and spend a reasonable sum				
	of his own money; an					
		license, unless otherwise				
	•	r 20 of the General Statutes.				
		ated in subsections (b) or (d)				
	of this section may be limited or restricted except					

Division of Health Service Regulation

STATE FORM 6899 6M3S11 If continuation sheet 4 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S	
744012744	or contraction	IDENTIFICATION NONDER.		A. BUILDING: _			
		MHL077-088		B. WING		10/1	C 10/2022
NAME OF P	ROVIDER OR SUPPLIER	ST	TREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
CHILD FA	C BASED CRISIS OF RIC	CHMOND-DAYMARK		US HIGHWAY			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 364	formulation of the clie plan. A written statem client's record that incomplete for the restriction. The reasonable and relate habilitation needs. A period not to exceed each restriction shall qualified professional at which time the rest Each evaluation of a documented in the clirights may be renewed statement entered by the client's record that renewal of the restrictic client who has not be in each instance of ar of a restriction of right by the client shall, up be notified of the rest it. In the case of a min adult client, the legall be notified of each insor renewal of a restriction of right by the client shall, up the client, the legall be notified of each insor renewal of a restriction of restric	essional responsible for the ent's treatment or habilitation that shall be placed in the dicates the detailed reason to restriction shall be end to the client's treatment restriction is effective for a 30 days. An evaluation of be conducted by the at least every seven days riction may be removed. The restriction shall be ent's record. Restrictions of the qualified professional at states the reason for the tion. In the case of an adult en adjudicated incompeted in initial restriction or renew the state of the clien riction and of the reason for the consent of the clien riction and of the reason for the consent of the clien riction and of the reason shall stance of an initial restriction of rights and of the	on or or in it nt, val d nt, or nt	V 364			
	This Rule is not met as evidenced by: Based on observation, records reviews and interviews, facility staff failed to ensure clients could make and receive confidential telephone calls affecting three of three current clients #1, #2		#2				

Division of Health Service Regulation

STATE FORM 6899 6M3S11 If continuation sheet 5 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		MHL077-088	B. WING		10/10/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
0 B = 4	0 D 4 0 E D 4 0 D 10 10 0 E D 14	523 NOR	TH US HIGHWA	Y 1, SUITE C	
CHILD FA	C BASED CRISIS OF RIC	CHMOND-DAYMARK ROCKING	HAM, NC 2837	'9	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETE
V 364	Continued From page	e 5	V 364		
	and #3.) and one form findings are:	mer client (FC #4.) The			
		f Client #1's record revealed:			
	-Admission date of 8/				
		bis Use D/O; Oppositional st Traumatic Stress Disorder;			
		sorder, Recurrent Episode,			
	Moderate.	portion, resument Episode,			
	-She was 17 years ol	d.			
		nentation in her record to			
	indicate staff could m	onitor her phone calls.			
	Review on 10/7/22 of -Admission date of 9/	f Client #2's record revealed: /7/22.			
		raumatic Stress Disorder;			
	Attention Deficit Hype				
		ractive/Impulse Presentation;			
	_	Disorder; Cannabis Abuse;			
	Disorder; Unspecified	ecified Bipolar and Related			
	-He was 15 years old				
		nentation in her record to			
	indicate staff could m	onitor her phone calls.			
	Review on 10/7/22 of	f Client #3's record revealed:			
	-Admission date of 9/				
		ve Attachment Disorder;			
		s Disorder; Intellectual			
	Developmental Disor				
	-She was 11 years of	a. nentation in her record to			
		nonitor her phone calls.			
	 Review on 10/7/22 of	f Former Client #4's record			
	revealed:				
	-Admission date of 8/				
	-Discharge date of 9/				
	-Diagnoses of Oppositional Defiant Disorder. History of Attention Deficit Hyperactivity Disorder				

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STATE FORM 6899 6M3S11 If continuation sheet 6 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/A IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL077-088		B. WING		l l	C / 10/2022
NAME OF PROVIDER OR SUPPLIER STREET ADD CHILD FAC BASED CRISIS OF RICHMOND-DAYMARK 523 NORTH			523 NORTH	RESS, CITY, STA I US HIGHWAY IAM, NC 2837	1, SUITE C		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 364	E OF PROVIDER OR SUPPLIER STREET ADDRI 523 NORTH I ROCKINGHA 1) ID SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)		V 364				

Division of Health Service Regulation

STATE FORM 6899 6M3S11 If continuation sheet 7 of 7