Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411015	A. BUILDING: _____ B. WING _____	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAYMARK GUILFORD RESIDENTIAL TREATMENT FA	5209 WEST WENDOVER AVENUE HIGH POINT, NC 27265

(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 survey was completed on 11/14/22. The complaint was unsubstantiated (intake # NC00194251). No deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .3400 Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders and 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency. This facility is licensed for 56 and currently has a census of 18. The survey sample consisted of audits of 1 former client.	V 000		

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