

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL076-134</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/11/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ASHEBORO CRISIS CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>110 WEST WAKER AVENUE, THIRD FLOOR ASHEBORO, NC 27203</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>An annual survey was completed on August 11, 2023. 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 Disability Groups.</p> <p>This facility is licensed for 16 and currently has a census of 16. The survey sample consisted of audits of 3 current clients.</p>	V 000		

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