

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL013-140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER FACILITY BASED CRISIS OF CABARRUS		STREET ADDRESS, CITY, STATE, ZIP CODE 280 EXECUTIVE PARK DRIVE, SUITE 160 CONCORD, NC 28025		
(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>An annual survey was completed on 10/12/23. 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 Group.</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		

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

TITLE

(X6) DATE