

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL077-088</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 05/08/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHILD FAC BASED CRISIS OF RICHMOND-DAYMARK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>523 NORTH US HIGHWAY 1, SUITE C ROCKINGHAM, NC 28379</b>		
(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>A complaint and follow-up survey was completed on May 8, 2025. The complaints (intake #NC00229203 and NC#00229185) were unsubstantiated. 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 15. 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