

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL019-069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2025
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NAME OF PROVIDER OR SUPPLIER DAYMARK RECOVERY SERVICES-CHATHAM COUNT	STREET ADDRESS, CITY, STATE, ZIP CODE 1105 EAST CARDINAL STREET SILER CITY, NC 27344
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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>INITIAL COMMENTS</p> <p>A complaint survey was completed on December 10, 2025. The complaints were unsubstantiated (intake #NC00234723 & #NC00234631). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G. 4400. Substance Abuse Intensive Outpatient Program (SAIOP).</p> <p>This facility has a current census of 8. The survey sample consisted of audits of 2 current clients, 1 former client.</p>	V 000		

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