

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL076-134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/16/2026
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NAME OF PROVIDER OR SUPPLIER ASHEBORO CRISIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST WAKER AVENUE, THIRD FLOOR ASHEBORO, NC 27203
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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>An annual and complaint survey was completed on January 16, 2025. The complaint was unsubstantiated intake #NC00235059. 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 has a current census of 13. The survey sample consisted of audits of 3 current clients and 1 former client.</p>	V 000		

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