

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL081-083</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/29/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DIRECTCARE COMMUNITY BASED SERVICES-DAY T</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>668 WITHROW ROAD, ROOMS 16 &amp; 18 FOREST CITY, NC 28043</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>A complaint survey was completed on April 29, 2026. The complaint was unsubstantiated (NC#00236507). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1400 Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances.</p> <p>This facility is licensed for 0 and has a current census of 0. The survey sample consisted of an audit of 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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