

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL032-133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/20/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>THE SHERMAN HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1712 SHERMAN AVENUE DURHAM, NC 27707</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>An annual survey was completed on 8/20/19. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities and 10A NCAC 27 G .5100 Community Respite for Individuals of all Disability Groups.</p>	V 000		

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