

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL032-363</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/22/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>TRIANGLE RESIDENTIAL OPTIONS FOR SUBSTANCE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1001 NORTH STREET DURHAM, NC 27701</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 November 22, 2022. No deficiencies cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .4300 Therapeutic Community.</p> <p>This facility is licensed for 178 and currently has a census of 142, The survey sample consisted of audits of 12 current clients.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE