

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-369	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2023
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NAME OF PROVIDER OR SUPPLIER DOWTIN'S THERAPEUTIC HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3912 WILLOW OAK ROAD RALEIGH, NC 27604
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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
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V 000	<p>INITIAL COMMENTS</p> <p>An annual was attempted on September 20, 2023. According to the Licensee there are no clients being served at the facility. The last time clients were served at the facility was September 2022.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>The Licensee stated that the last client passed away September 2, 2022. She is currently meeting with her Local Management Entity-Managed Care Organization to admit new clients.</p>	V 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____