Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-596	A. BUILDING: ______ B. WING ______	**07/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A POSITIVE SOLUTION	**228 SOUTH BEND DRIVE** **DURHAM, NC 27713**

(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	INITIAL COMMENTS An annual survey was attempted on July 19, 2024. According to the Licensee, there are no clients being served at the facility. The last time clients were at the facility was in February, 2024. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living: Alternative Family Living in a Private Residence. Interview on 7/19/24 at 9:05 am with the Licensee revealed: -He was not home and on his way out of town. -He did not have any clients at the facility. -His last client was discharged from the facility on February of 2024. -He was planning to provide services again in the future, but was giving himself some time off. -He wanted to start receiving new clients again sometime in the Winter. Probably December 2024 or January 2025. -Licensee was informed to contact South Piedmont Team Supervisor once new clients begin receiving services at the facility.	V 000		

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