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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL032-335	B. WING		08/12/2024		
ame of Pf	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
URHAM	WOMEN'S HALFWAY H	DUSE	M, NC 27703				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE		
∨ 000	INITIAL COMMENTS		V 000				
	An annual survey was completed on August 12, 2024. A deficiency was cited.						
	This facility is licensed for the following service category: 10A NCAC 27G. 5600E Supervised Living for Substance Abuse Adults						
	census of 6.	d for 6 and currently has a onsisted of audits of 3					
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736				
		EMENTS					
	failed to ensure the fa	as evidenced by: n and interviews, the facility acility was maintained in a ctive manner. The findings					
	-Missing front part of missing. -The bottom drawer of broken.	4 at 9:30 a.m. revealed: a kitchen drawer was of the stove was off track or very coordinator was using					
	the stove at the time.						
	revealed:	with the Residential Director ve and prepared their own					

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-335			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		08	08/12/2024	
	ROVIDER OR SUPPLIER	OUSE 407 SAL	ADDRESS, CITY, STATE .EM STREET M, NC 27703	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE	
V 736	-Clients were respon broken or not working -The house manager order. -The facility had their	sible for reporting anything	V 736			

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