

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-582	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/25/2024
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER TRIANGLE RESIDENTIAL OPTIONS FOR SUBS	STREET ADDRESS, CITY, STATE, ZIP CODE 1820 JAMES STREET DURHAM, NC 27707
----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------

(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>INITIAL COMMENTS</p> <p>An annual survey was completed on September 25, 2024. No deficiencies were 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 275 and has a current census of 214. The survey sample consisted of audits of 10 current clients.</p>	V 000		

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