

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL032-586</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/09/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RECOVERY CONNECTIONS I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2203 ELMWOOD AVENUE DURHAM, NC 27707</b>
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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
V 000	<p><b>INITIAL COMMENTS</b></p> <p>A annual and follow up survey was attempted on October 9, 2024. According to the Facility Director there are no clients being served at the facility. The last time clients were served at the facility was May 2024.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency.</p> <p>Interview on October 9, 2024, with the Facility Director stated that the Owner passed away earlier this year. Due to the Owner's passing the facility closed and will not reopen.</p>	V 000		

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