

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032349	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WINBURN	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 WINBURN AVENUE DURHAM, NC 27704
--	--

(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 October 25, 2024. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 750	<p>27G .0304(b)(3) Maintenance of Elec., Mech., & Water Systems</p> <p>10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT</p> <p>(b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors.</p> <p>(3) Electrical, mechanical and water systems shall be maintained in operating condition.</p> <p>This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to maintain electrical systems in safe operating conditions. The findings are:</p> <p>Observation on 10/25/24 from about 8:30 am to 12:00 pm of the facility revealed:</p> <ul style="list-style-type: none"> -Smoke detector located at the end of the upstairs hallway made the alarm warning noises (chirping sounds) indicating that the batteries needed replacing. -Smoke detector located inside the bedroom 	V 750		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032349	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WINBURN	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 WINBURN AVENUE DURHAM, NC 27704
--	--

(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 750	<p>Continued From page 1</p> <p>located upstairs at the end of the hallway and to the left made the alarm warning noises (chirping sounds) indicating that the batteries needed replacing.</p> <p>Interview on 10/25/24 with the House Manager revealed: -He had been at the facility the night before the survey and the smoke detectors had not been chirping. -He acknowledged the facility failed to ensure the smoke detectors were maintained in operating conditions.</p>	V 750		