

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/01/2025
NAME OF PROVIDER OR SUPPLIER TRIANGLE RESIDENTIAL OPTIONS FOR SUBS		STREET ADDRESS, CITY, STATE, ZIP CODE 1815 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>A complaint survey was completed on May 1, 2025. The complaint was unsubstantiated (intake #NC00228989). 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 92 and has a current census of 43. The survey sample consisted of audits of 1 former client.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE