

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/28/2025
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NAME OF PROVIDER OR SUPPLIER TRIANGLE RESIDENTIAL OPTIONS FOR SUBS	STREET ADDRESS, CITY, STATE, ZIP CODE 201 BROADWAY STREET APT 1,2,3,5,6,7,8 DURHAM, NC 27701
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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>INITIAL COMMENTS</p> <p>An annual and follow up survey was attempted on October 28, 2025. According to the Director of Compliance there are no clients being served at the facility. The last time clients were served at the facility was 8/31/25.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .4300 Therapeutic Community.</p> <p>Interview on 10/28/25 with the Director of Compliance revealed:</p> <ul style="list-style-type: none"> -There were no clients residing at the facility. -The last client served was 8/31/25. -Three people were residing at the facility, but they were staff that had just finished the program and were hired by the agency. -It was unknown on when new clients would be admitted to the facility. -Agency was focusing on having all residents live on the main campus. -Plans were to continue to use the facility in the near future once the client's population grows. 	V 000		

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