

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060159</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/11/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CADENCE SENIOR LIVING AT MINT HILL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5601 MARGARET WALLACE ROAD MATTHEWS, NC 28105</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
{C 000}	<p>Initial Comments</p> <p>Report of a Follow Up Construction Survey by documentation by Tod Hancock. Based on your acceptable Plan of Correction received on June 6, 2025, for our Biennial Construction Follow Up Survey, all previously cited deficiencies are noted as being corrected. Therefore, no further action is required.</p>	{C 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_