

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL092219</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/01/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CARY FAMILY CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>545 FRONT RIDGE DRIVE CARY, NC 27519</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 by Jonathan Gamsey</p> <p>Based on your acceptable Plan of Corrections received on June 21 , 2024 for a Biennial Construction 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 \_\_\_\_\_