

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL032181 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/27/2024 |
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| NAME OF PROVIDER OR SUPPLIER LIVEWELL DURHAM AT HOPE VALLEY | STREET ADDRESS, CITY, STATE, ZIP CODE 3736 BENTLEY DR DURHAM, NC 27707 |
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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 |
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| {C 000} | <p>Initial Comments</p> <p>Report by Scott Greenwood</p> <p>DHSR Construction Section conducted a Biennial Follow Up Survey on March 27, 2024 from 10:10 AM to 10:30 AM. At the time of the follow up survey all of the previously cited deficiencies have been corrected. . Therefore no further action is required.</p> | {C 000} | | |
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| Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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