

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064036 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____ | (X3) DATE SURVEY COMPLETED R 05/21/2024 |
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| NAME OF PROVIDER OR SUPPLIER NAVION OF ROCKY MOUNT | STREET ADDRESS, CITY, STATE, ZIP CODE 650 GOLDROCK ROAD ROCKY MOUNT, NC 27804 |
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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 of a Biennial Follow Up Construction Survey by Suzanna Fay conducted on May 21, 2024.</p> <p>Deficiencies noted during the Biennial Construction Survey have been corrected and no further action is required at this time.</p> | {C 000} | | |

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