

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL010011</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>03/06/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OCEAN ISLE OPERATIONS</b> |                                                                                                                                                                                                     |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5490 ARBOR BRANCH DRIVE</b><br><b>SHALLOTTE, NC 28470</b>                    |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                        | ID<br>PREFIX<br>TAG                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {C 000}                                                          | <p>Initial Comments</p> <p>Report of a Biennial Construction Follow-Up Survey by Ryan Meyer conducted on March 6 2024.</p> <p>All deficiencies have been corrected. No further action required.</p> | {C 000}                                                                       |                                                                                                                          |                          |                                                                    |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE