

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011195	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 03/27/2024
NAME OF PROVIDER OR SUPPLIER EVERGREEN LIVING HOME #3		STREET ADDRESS, CITY, STATE, ZIP CODE 103 COUNTRY TIME LANE LEICESTER, NC 28748		
(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}	Initial Comments Report by Jonathan Gamsey DHSR Construction Section conducted a Biennial Follow Up Survey on March 27, 2024 from 08:20 AM to 08:30 AM. At the time of the follow up survey all of the previously cited deficiencies have been corrected. Therefore no further action is required.	{C 000}		

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

TITLE

(X6) DATE