

Division of Health Service Regulation

|                                                                                 |                                                                                                                                                                                                                                                                                                                           |                                                                                             |                                                                                                                          |                                                                    |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                             |                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL045088</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>03/26/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUNDVIEW FAMILY CARE HOMES - UNIT D</b> |                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>43 OXBOW LANE</b><br><b>FLAT ROCK, NC 28731</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 by David Hickman</p> <p>DHSR Construction Section conducted a Biennial Follow-up Survey on March 26, 2024 from 12:00 PM to 12:20 PM at the above referenced facility. All previously cited deficiencies were verified as being corrected. Therefore, no further action is required.</p> | {C 000}                                                                                     |                                                                                                                          |                                                                    |

Division of Health Service Regulation

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

TITLE

(X6) DATE