

Division of Health Service Regulation

|                                                                      |                                                                                                                                                                                                                                                                                                                         |                                                                               |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL011288</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>03/27/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EVERGREEN LIVING HOME #12</b> |                                                                                                                                                                                                                                                                                                                         |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>352 FAMILY RIDGE ROAD<br/>LEICESTER, NC 28748</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 Jonathan Gamsey</p> <p>DHSR Construction Section conducted a Biennial Follow Up Survey on March 27, 2024 from 08:50 AM to 09:10 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}                                                                       |                                                                                                                          |                          |                                                                    |

Division of Health Service Regulation

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

TITLE

(X6) DATE