

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>HAL002003</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>02/27/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TAYLORSVILLE HOUSE</b> |                                                                                                                                                                                                           |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>350 SCHOOL DRIVE</b><br><b>TAYLORSVILLE, NC 28681</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 Construction Section Biennial Survey Follow Up by Tod Hancock, conducted on February 27, 2024.</p> <p>Corrections have been made. No further action is needed.</p> | {C 000}                                                                       |                                                                                                                          |                          |                                                                    |

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

TITLE

(X6) DATE