

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL045102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 03/26/2024
NAME OF PROVIDER OR SUPPLIER SOUNDVIEW FAMILY CARE HOME UNIT N		STREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST MONET COURT FLAT ROCK, NC 28731		
(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 David Hickman DHSR Construction Section conducted a Biennial Follow-up Survey on March 26, 2024 from 1:00 PM to 1:20 PM at the above referenced facility. All previously cited deficiencies were verified as being 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