

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>HAL013052</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>03/05/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CAREMOOR RETIREMENT CENTER</b> |                                                                                                                                                                                                                |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4876 CAREMOOR PLACE</b><br><b>KANNAPOLIS, NC 28081</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 Construction Section Follow Up<br/>Biennial Survey by Tod Hancock conducted on<br/>March 5, 2024.</p> <p>Corrections have been made. No further action is<br/>needed.</p> | {C 000}                                                                       |                                                                                                                          |                          |                                                                    |

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

TITLE

(X6) DATE