

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL068036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 06/19/2024
NAME OF PROVIDER OR SUPPLIER LIVEWELL ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 6720 PAULINE DRIVE CHAPEL HILL, NC 27514		
(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 June 19, 2024. At the time of the survey, all of the previously cited deficiencies had been corrected, therefore no further action is required.	{C 000}			

Division of Health Service Regulation

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

TITLE

(X6) DATE