

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092237	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 06/17/2024
NAME OF PROVIDER OR SUPPLIER AVENDELLE ASSISTED LIVING ON MAYNARD			STREET ADDRESS, CITY, STATE, ZIP CODE 1537 GREEN MOUNTAIN DRIVE CARY, NC 27511		
(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 Kelly Myers Based on your acceptable Plan of Corrections received on April 30, 2024, for a Biennial Construction Survey, all previously cited deficiencies are noted as being corrected through documentation. Therefore no further action is required.	{C 000}			

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

TITLE

(X6) DATE