

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL030009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 06/25/2024
NAME OF PROVIDER OR SUPPLIER MOCKSVILLE SENIOR LIVING & MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 337 HOSPITAL STREET MOCKSVILLE, NC 27028		
(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 of a Construction Section Biennial Follow Up Survey by Tod Hancock, conducted on June 25, 2024. Deficiencies have been corrected. No further action is necessary.	{C 000}			

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

TITLE

(X6) DATE