

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 03/19/2025
NAME OF PROVIDER OR SUPPLIER DEVOTED ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 HWY 135 STONEVILLE, NC 27048		
(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 Follow Up Construction Survey by documentation by Tod Hancock. Based on your acceptable Plan of Correction received on November 1, 2024, for our Biennial Construction Survey, all previously cited deficiencies are noted 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