

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL051048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 05/16/2024
NAME OF PROVIDER OR SUPPLIER GABRIEL MANOR ASSISTED LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 84 JOHNSON ESTATE RD CLAYTON, NC 27520		
(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 Construction Section Biennial Follow-Up Survey report by Ryan Meyer was conducted on May 16, 2024. All deficiencies have been corrected. No further action required.	{C 000}			

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

TITLE

(X6) DATE