

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001159	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 10/08/2024
NAME OF PROVIDER OR SUPPLIER MEBANE RIDGE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1999 SOUTH NC HWY 119 MEBANE, NC 27302		
(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 Ed Miller, conducted on October 8, 2024. All previously cited 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