

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0383	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2025
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NAME OF PROVIDER OR SUPPLIER DAN E. & MARY LOUISE STEWART H	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 SAWMILL ROAD RALEIGH, NC 27615
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(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
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L 000	<p>INITIAL COMMENTS</p> <p>An unannounced onsite re-licensure survey was conducted on 10/14/25 through 10/16/25. This facility is in compliance with the requirements of 10A NCAC 13D Rules for the Licensing of Nursing Homes (General Health Survey). No deficiencies were cited on this re-licensure survey. Event ID# 4V6411.</p>	L 000		
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Division of Health Service Regulation	LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	<i>Jessica Pagan, RNHA</i>	<i>Administrator</i>	<i>10/24/25</i>