STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED R-C 04/17/202 NAME OF PROVIDER OR SUPPLIER THE OAKS AT SWEETEN CREEK STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704 STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704	DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.							
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the facility is back into compliance effective	F 000	INITIAL COMMENTS		F	000			
		the facility is back into						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DAT							(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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