DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2011 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
345219		B. WING			C 04/06/2011	
NAME OF PROVIDER OR SUPPLIER BRITTHAVEN OF MORGANTON			STREET ADDRESS, CITY, STATE, ZIP CODE 107 MAGNOLIA DR MORGANTON, NC 28655			0/2011
(4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORRECTIVE ACTION SH	ON SHOULD BE COMPLETION BE APPROPRIATE DATE	
00 INITIAL COMMENTS		F	000			
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	OVIDER OR SUPPLIER /EN OF MORGANTON SUMMARY ST. (EACH DEFICIENC' REGULATORY OR I INITIAL COMMENTS No deficiencies cited investigation event ID	OVIDER OR SUPPLIER /EN OF MORGANTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies cited as result of complaint investigation event ID# 5XXE11.	A. BUIL 345219 OVIDER OR SUPPLIER /EN OF MORGANTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS F (No deficiencies cited as result of complaint	OVIDER OR SUPPLIER JEN OF MORGANTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) No deficiencies cited as result of complaint investigation event ID# 5XXE11.	OVIDER OR SUPPLIER /EN OF MORGANTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies cited as result of complaint investigation event ID# 5XXE11.	OWIDER OR SUPPLIER 345219 STREET ADDRESS, CITY, STATE, ZIP CODE 107 MORGANTON, NC 28655 SUMMARY STATEMENT OF DEPOIENCIES (EACH DEPOIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies cited as result of complaint investigation event ID# 5XXE11.

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.