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

PRINTED: 10/14/2014 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER THE SHANNON GRAY REHABILITATION & RECOVERY CENTER (A) ID (EACH DEFICIENCE STAGE SHOULD REGULATORY OR LSC IDENTIFYING INFORMATION) FOUR INITIAL COMMENTS The facility is in compliance with the requirements of 42 CRF Part 483, Subpart B for Long Term Care Facilities (General Health Survey). STREET ADDRESS, CITY, STATE, ZIP CODE 2005 SHANNON GRAY GOURT JAMESTOWN, NC 27282 PROVIDENS FLANT OF CORRECTION (PS) TRANSPORT OF CORRECTION (PS) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FOUR INITIAL COMMENTS The facility is in compliance with the requirements of 42 CRF Part 483, Subpart B for Long Term Care Facilities (General Health Survey).	AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER THE SHANNON GRAY REHABILITATION & RECOVERY CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 2005 SHANNON GRAY COURT JAMESTOWN, NC 27282			345552	B. WING				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS The facility is in compliance with the requirements of 42 CRF Part 483, Subpart B for Long Term Care Facilities (General Health (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FOOD FREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FOOD LONG THE APPROPRIATE DEFICIENCY FOOD The facility is in compliance with the requirements of 42 CRF Part 483, Subpart B for Long Term Care Facilities (General Health)	NAME OF PROVIDER OR SUPPLIER				2005 SHANNON GRAY COURT	DE	10/03/2014	
The facility is in compliance with the requirements of 42 CRF Part 483, Subpart B for Long Term Care Facilities (General Health	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	F 000	The facility is in co requirements of 42 Long Term Care Fa	mpliance with the CRF Part 483, Subpart B for	FO				

Electronically Signed

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.

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

TITLE

(X6) DATE