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

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AMME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ROSE MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4230 NORTH ROXBORO ROAD DURHAM, NC 27704 (X5)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ROSE MANOR (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS There were no deficiencies as a result of the Complaint investigation survey completed on 3/27/15. Event ID#VWFN11. Complaint Intake #'s						С	
KINDRED TRANSITIONAL CARE & REHAB-ROSE MANOR 4230 NORTH ROXBORO ROAD DURHAM, NC 27704 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS There were no deficiencies as a result of the Complaint investigation survey completed on 3/27/15. Event ID#VWFN11. Complaint Intake #'s			345081	B. WING		03/	27/2015
CALC DURHAM, NC 27704 CALC CA	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS F 000 There were no deficiencies as a result of the Complaint investigation survey completed on 3/27/15. Event ID#VWFN11. Complaint Intake #'s	KINDRED TRANSITIONAL CARE & REHAR ROSE MANOR				4230 NORTH ROXBORO ROAD		
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There were no deficiencies as a result of the Complaint investigation survey completed on 3/27/15. Event ID#VWFN11. Complaint Intake #'s	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFI	X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
Complaint investigation survey completed on 3/27/15. Event ID#VWFN11. Complaint Intake #'s	F 000	F 000 INITIAL COMMENTS		FC	000		
		Complaint investiga 3/27/15. Event ID#VWFN11	ation survey completed on . Complaint Intake #'s				

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

TITLE

Facility ID: 923269

Electronically Signed

04/07/2015

(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.