DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED						
RS FOR MEDICARE	& MEDICAID SERVICES				. 0938-0391	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	(X3) DATE SURVEY COMPLETED	
345372		B. WING		C 05/16/2015		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WILSON PINES NURSING AND REHABILITATION CENTER			403 CRESTVIEW AVENUE WILSON, NC 27893			
D SUMMARY STATEMENT OF DEFICIENCIES IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	HOULD BE COMPLÉTION		
00 INITIAL COMMENTS		F 00	о			
No deficiencies we	ere cited as a result for the					
	DER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE 05/18/2015	
	RS FOR MEDICARE OF DEFICIENCIES PROVIDER OR SUPPLIER PINES NURSING AN SUMMARY STI (EACH DEFICIENCI REGULATORY OR L INITIAL COMMENT No deficiencies we complaint investiga	RS FOR MEDICARE & MEDICAID SERVICES         IT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         DE CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:       345372         PROVIDER OR SUPPLIER       PINES NURSING AND REHABILITATION CENTER         SUMMARY STATEMENT OF DEFICIENCIES       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         INITIAL COMMENTS       No deficiencies were cited as a result for the complaint investigation. Event ID # TQ0111         VDIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SUMECTOR'S OR PROVIDER'S SUMECTOR'S OR PROVIDER'SUPPLIER REPRESENTATIVE'S SUMECTOR'S OR PROVIDER'SUPPLIER REPRESENTATIVE'S SUMECTOR'S OR PROVIDER'SUPPLIER REPRESENTAT	RS FOR MEDICARE & MEDICAID SERVICES         I OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         DENTIFICATION NUMBER:       A BUILDIN         345372       B. WING_         PROVIDER OR SUPPLIER       B. WING_         PINES NURSING AND REHABILITATION CENTER       ID         INITIAL COMMENTS       PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         INITIAL COMMENTS       F 00         No deficiencies were cited as a result for the complaint investigation. Event ID # TQ0111       F 00	RS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (x1) PROVIDERSUPPLIER (L1A)         JUDRNTIFICATION NUMBER:       A. BUILDING         JA5372       B. WING    PROVIDER OR SUPPLIER PINES NURSING AND REHABILITATION CENTER INSON OR DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGC IDENTIFYING INFORMATION)       Image: Deficiencies (EACH CORRECTIVE ACTION & CROSS-REFERENCE)         INITIAL COMMENTS       F 000         INITIAL COMMENTS       F 000	IMENT OF HEALTH AND HUMAN SERVICES       DOME NO         SP COR MEDICARE & MEDICAID SERVICES       ONB NO         OP DEFICIENCIES       (X) PROVIDERSUPPLIENCIA       (X2) MULTIPLE CONSTRUCTION       (X3) MULTIPLE         PROVIDER OR SUPPLIEN       345372       B. WING       (X3) MULTIPLE       (X3) MULTIPLE         PROVIDER OR SUPPLIEN       STREET ADDRESS, CITY, STATE, ZIP CODE       (3) GREETOREW AVENUE       (X2) MULTIPLE       (X3) MULTIPLE         PROS NURSING AND REHABILITATION CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE       (3) GREETOREW AVENUE       (X2) MULTIPLE       (GEAH OEFICIENCY MUST BE PRECEDED BY FULL         REGULATORY OR LSC DENTIFYING INFORMATION)       INCOME       PROVIDERS PLAN OF CORRECTION       (EACH OEFICIENCY AUST BE PRECEDED BY FULL         REGULATORY OR LSC DENTIFYING INFORMATION)       INCOME       F000       FORMERCENCY AUST BE PRECEDED BY FULL         NO deficiencies were cited as a result for the complaint investigation. Event ID # TQ0111       F 000       FORMERCENCY         NO deficiencies were cited as a result for the complaint investigation. Event ID # TQ0111       F 000       FILE	

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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