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

PRINTED: 02/16/2016 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 139 ONSLOW DRIVE EXTENSION JACKSONVILLE, DR. 2840	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 CAROLINA RIVERS NURSING AND REHABILITATION CENTER JACKSONVILLE, INC. 2840 (24) ID PRETTY, INC. 2840 PRETTY, INC. PROVIDERS PLATO FOR CRETCHON REQUIATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 2/2/2/2016. Event ID# 3R/211.							С	
CAROLINA RIVERS NURSING AND REHABILITATION CENTER (M4) ID PREFIX TAG (M4) ID PREFIX (REGULATORY OR LSC IDENTIFYING INFORMATION) FOR INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 2/2/2/2016. Event ID# 3/RI211.			345072	B. WING			02/	02/2016
CARCINA RIVERS NURSING AND REHABILITATION CENTER JACKSONVILLE, NC 28540	NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
CALL DEPOIL	CAROLINA DIVERS MURONO AND DELLA DIVERSION CENTERS				1839 ONSLOW DRIVE EXTENSION			
PREFIX TAG REQULATORY OR LSC IDENTIFYING INFORMATION) FORM FORM INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 2/2/2016. Event ID# 3RI211. FORM REQULATORY OR LSC IDENTIFYING INFORMATION) FORM FORM REQULATORY OR LSC IDENTIFYING INFORMATION) FORM FORM CAGAS REFERENCED TO THE APPROPRIATE CAGSS REFERENCED TO THE APPROPRIATE CAGS REFERENC	CAROLINA RIVERS NURSING AND REHABILITATION CENTER				JACKSONVILLE, NC 28540			
No deficiencies were cited as a result of the complaint investigation survey of 2/2/2016. Event ID# 3RI211.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BI		COMPLETION
complaint investigation survey of 2/2/2016. Event ID# 3RI211.	F 000	10 INITIAL COMMENTS		F	000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		complaint investigation						
					TITLE			

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.

Electronically Signed

02/03/2016