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

PRINTED: 12/12/2016 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ROSE MANOR  DIAHAM, NO 27704  PRETTY, TAG  REGULATORY OR ISO IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  NO deficiencies were cited as a result of the complaint investigation survey 11/23/16. Event ID# 2 DO111.	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  UNITIAL COMPAND  GAI ID PREFIX TAG  GAI ID PREFIX TAG  WE GACH DEPTICE OF MISS OF PROCEEDED BY PULL REGULATORY OR USE OF DEVINION INFORMATION)  F 000 INITIAL COMMENTS  No deficiencies were cited as a result of the complaint investigation survey 11/23/16. Event ID# 2DO111.			245004					
CALL   DEPARTMENT OF DEFICIENCIES   CALL   DEFICIENCY MUST ARE REPORTED BY FILL   TAGK   TAGK   DEPARTMENT OF DEFICIENCES   TAGK   TAGK   DEPARTMENT OF DEFICIENCES   TAGK   TA	l l						11/23/2016	
CALL	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE							
CMJ ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PREFEX   REGULATORY OR ISC IDENTIFYING INFORMATION   PREFEX   TAG   REGULATORY OR ISC IDENTIFYING INFORMATION    F 000 INITIAL COMMENTS   F 000   R	KINDRED TRANSITIONAL CADE & DEHAR BOSE MANOR				4230 NORTH ROXBORO ROAD			
PREFIX TAG  ICACH DEFICIENCY NUSTS REPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FROM  INITIAL COMMENTS  No deficiencies were cited as a result of the complaint investigation survey 11/23/16. Event ID# 2D0111.	MINDRED INCHORNE CARE & REHAD-ROOF MARON				DURHAM, NC 27704	URHAM, NC 27704		
No deficiencies were cited as a result of the complaint investigation survey 11/23/16. Event ID# 2DO111.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BI		COMPLETION
complaint investigation survey 11/23/16. Event ID# 2DO111.	F 000	00 INITIAL COMMENTS		F	000			
		complaint investigation						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (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

FORM CMS-2567(02-99) Previous Versions Obsolete

**Electronically Signed** 

program participation.

12/12/2016