PRINTED: 10/10/2017 FORM APPROVED

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  STANLEY TOTAL LIVING CENTER  STANLEY TOTAL LIVING CENTER  STANLEY TOTAL LIVING CENTER  STANLEY NOT ALL LIVING CENTER  STANLEY NOT ALL LIVING CENTER  STANLEY NOT ALL LIVING CENTER  STANLEY NOT 28164  PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  INITIAL COMMENTS  No deficiencies cited as result of survey event ID# RVZ.J11.	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  STREET ADDRESS, CITY, STATE, ZIP CODE  STANLEY TOTAL LIVING CENTER  STANLEY, NC 28164   (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  L 000 INITIAL COMMENTS  No deficiencies cited as result of survey event    B. WING				A. BUILDING.				
STANLEY TOTAL LIVING CENTER  514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  L 000 INITIAL COMMENTS  No deficiencies cited as result of survey event  L 000 No deficiencies cited as result of survey event	NH0386		B. WING					
STANLEY, NC 28164  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  L 000 INITIAL COMMENTS  No deficiencies cited as result of survey event  STANLEY, NC 28164  STANLEY, NC 28164  ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE)  COMPLETE DATE	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  L 000 INITIAL COMMENTS  No deficiencies cited as result of survey event  L 000 RESCRIPTION SHOULD BE COMPLÉTE DATE  CROSS-REFERÊNCED TO THE APPROPRIATE DEFICIENCY)  L 000 No deficiencies cited as result of survey event	STANLEY TOTAL LIVING CENTER							
No deficiencies cited as result of survey event	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETE	
	L 000	INITIAL COMMENTS		L 000				
		No deficiencies cited						

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

(X6) DATE TITLE

**Electronically Signed** 

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