| DEPARTMENT OF HEALTH AND HUMAN SERVICES | | | | | FORM APPROVED | |
|--|---|--|--|---|--|--|
| | | | | | OMB NO. 0938-0391 | |
| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED | |
| | 345285 | B. WING _ | | | C 12/14/2017 | |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| | | | 200 HERITAGE DRIVE | | | |
| | ENAD | | HENDERSONVILLE, NC 2 | 8739 | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | | | AN OF CORRECTION | (X5) | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | | | | |
| | | IAG | | | | |
| No deficiencies were | cited as a result of this | F(| 000 | | | |
| | | | | | | |
| | | | TITLE | | (X6) DATE | |
| | RS FOR MEDICARE & | RS FOR MEDICARE & MEDICAID SERVICES IOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345285 PROVIDER OR SUPPLIER IN HOME HEALTH AND REHAB 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 of this complaint investigation. Event ID# 2W7411. | RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 345285 B. WING PROVIDER OR SUPPLIER B. WING IN HOME HEALTH AND REHAB ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID INITIAL COMMENTS F C No deficiencies were cited as a result of this F C | RS FOR MEDICARE & MEDICAID SERVICES Or DEFICIENCIES (X1) PROVIDERSUPPLERCULA DENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING STREET ADDRESS. CITY, STATE IN HOME HEALTH AND REHAB STREET ADDRESS. CITY, STATE 200 HERTIAGE DRIVE HENDERSONVILLE, NC 201 PREVIDENCY OR USE TO PERCIENCIES (EACH DEFICIENCY USET BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREVIDENCY PREVIDENCY REGULATORY OR LSC IDENTIFYING INFORMATION) PREVIDENCY PREVIDENCY REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS F 000 | IMENT OF HEALTH AND HUMAN SERVICES (2) MULTIPLE CONSTRUCTION SF COR MEDICARE & MEDICALOB SERVICES (2) MULTIPLE CONSTRUCTION IF CORRECTION (1) PROVIDERSUPPLERCIA (2) MULTIPLE CONSTRUCTION 345285 II. WING | |

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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