CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING         NAME OF PROVIDER OR SUPPLIER       345397       B. WING         SHORELAND HLTH CARE & RETIREME       STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)         F 000       INITIAL COMMENTS       F 000	CTION OULD BE	D. 0938-0391 E SURVEY PLETED /19/2018
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING B. WING NAME OF PROVIDER OR SUPPLIER SHORELAND HLTH CARE & RETIREME USUMMARY STATEMENT OF DEFICIENCIES PREFIX (K4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG SUMMARY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG CROSS-REFERENCED TO THE APPL DEFICIENCY		PLETED
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       SHORELAND HLTH CARE & RETIREME     200 FLOWER-PRIDGEN DRIVE       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)	CTION OULD BE	
SHORELAND HLTH CARE & RETIREME       200 FLOWER-PRIDGEN DRIVE         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG	OULD BE	(X5)
SHORELAND HLTH CARE & RETIREME       WHITEVILLE, NC 28472         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECT         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       PREFIX       (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5)
WHITEVILLE, NC 28472         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG       CROSS-REFERENCED TO THE APPLICIENCY)	OULD BE	(X5)
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5)
F 000 INITIAL COMMENTS F 000		COMPLETION DATE
The facility is in compliance with the requirements of 42 CFR part 483, Subpart B for LTC facilities Event ID #MWR911.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Electronically Signed		(X6) DATE 02/01/2018

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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