IEALTH AN	ID HUMAN SERVICES					RM APPROVED
DICARE &	MEDICAID SERVICES					NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345349	B. WING			C 02/15/2018	
UPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 1	02/15/2016
WOODBURY WELLNESS CENTER INC			2778	COUNTRY CLUB DRIVE		
SS CENTER	(INC		HAN	IPSTEAD, NC 28443		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION S		JLD BE	(X5) COMPLETION DATE
INITIAL COMMENTS		F 000				
R PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE 02/19/2018
	DICARE &	IDENTIFICATION NUMBER: <u>345349</u> SUPPLIER SS CENTER INC SUMMARY STATEMENT OF DEFICIENCIES CD DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) OMMENTS re no citations issued as a result of a investigation, Event NHTN11, exit date R PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATU	DICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IS (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT JUPLIER 345349 B. WING_ SS CENTER INC ID PREFL SUMMARY STATEMENT OF DEFICIENCIES ID PREFL COMMENTS F (ID) PREFL OMMENTS F (ID) PREFL re no citations issued as a result of a investigation, Event NHTN11, exit date ID) INVESTIGATION, Event NHTN11, exit date ID) R PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ID)	DICARE & MEDICAID SERVICES IES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CA JUENTIFICATION NUMBER: A. BUILDING JUPPLIER TRI SIMMARY STATEMENT OF DEFICIENCIES JD SUMMARY STATEMENT OF DEFICIENCIES JD SUMMARY STATEMENT OF DEFICIENCIES JD SUMMARY STATEMENT OF DEFICIENCIES JD ONMENTS F 000 re no citations issued as a result of a investigation, Event NHTN11, exit date Investigation, Event NHTN11, exit date	DICARE & MEDICAID SERVICES Image: Service of the service of t	Ideal_ITMAND_HUMAND_SERVICES FG DICARE & MEDICADD SERVICES OMBI ES [x1] PROVIDERSUPPLIERCLA [x2] MULTIPLE CONSTRUCTION [x3] DL IDENTIFICATION NUMBER [x2] MULTIPLE CONSTRUCTION [x3] DL STREET ADDRESS, CITY, STATE, 2P CODE [x7] COUNTRY CULD BORNE SUMMARY STATEMENT OF DEFICIENCIES [Y2] PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES [Y2] PROVIDERS PLAN OF CORRECTION SHOULD BE DURATORY OR LSC IDENTIFYING INFORMATION [Y6] PROVIDERS PLAN OF CORRECTION SHOULD BE OMMENTS F0 000

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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