AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETE A. BUILDING CC 345413 B. WING 10/16/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3016 CANE CREEK ROAD FAIRVIEW, NC 28730 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM APPROVED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391	
Image: Name of provider or supplier Street Address, city, state, zip code 10/16/2 FLESHERS FAIRVIEW HEALTH CARE STREET Address, city, state, zip code (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COL F 000 INITIAL COMMENTS F 000 <td colspan="2" rowspan="2"></td> <td></td> <td></td> <td colspan="2"></td> <td colspan="2">(X3) DATE SURVEY COMPLETED</td>							(X3) DATE SURVEY COMPLETED	
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	F 000	INITIAL COMMENTS	;	FC	000			
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) D							(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 program participation.

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