POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
345363 _{Y1}	B. Wing	Y2	4/3/2019	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE PRESBYTERIAN HOME OF H	HAWFIELDS	2502 S NC 119		
		MEBANE, NC 27302		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM DATE		ITEM		DATE	ITEM		DATE	
Y4 Y5		Y4		Y5	Y4		Y5	
ID Prefix Reg. # LSC	F0600 483.12(a)(1)	Correction Completed 03/15/2019		F0865 483.75(a)(2)(h)(i)	Correction Completed 03/15/2019	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
REVIEWEI STATE AG REVIEWEI CMS RO		REVIEWED BY (INITIALS) REVIEWED BY (INITIALS) DMPLETED ON		SIGNATURE OF TITLE		. WAS A SUMMA	DATE DATE	
2/15/2019				RRECTED DEFICIENCIE				