## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2019 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
	345245	B. WING _		06/05/2019	
NAME OF PROVIDER OR SUPPLIER  PENDER MEMORIAL HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE  507 E FREMONT STREET  BURGAW, NC 28425		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE COMPLETION THE APPROPRIATE	
E 000 Initial Comments		E	000		
conducted 06/02/19-0 found in compliance v	06/05/19. The facility was with the requirement CFR				
000 INITIAL COMMENTS		FO	000		
requirements of 42CF	R Part 483, Subpart B for				
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY ST.  (EACH DEFICIENC REGULATORY OR I  Initial Comments  An unannounced Re conducted 06/02/19-0 found in compliance of 483.73, Emergency F ID#GYXF11 INITIAL COMMENTS  The facility is in comprequirements of 42CF	An unannounced Recertification survey was conducted 06/02/19-06/05/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#GYXF11	A. BUILDI  345245  B. WING_ ROVIDER OR SUPPLIER  MEMORIAL HOSP SNF  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Initial Comments  An unannounced Recertification survey was conducted 06/02/19-06/05/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#GYXF11 INITIAL COMMENTS  The facility is in compliance with the requirements of 42CFR Part 483, Subpart B for	ROVIDER OR SUPPLIER  MEMORIAL HOSP SNF  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A. BUILDING  STREET ADDRESS, CITY, STATE, ZIP  507 E FREMONT STREET BURGAW, NC 28425  ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Initial Comments  A. BUILDING  STREET ADDRESS, CITY, STATE, ZIP  507 E FREMONT STREET BURGAW, NC 28425  ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN  TAG  A. BUILDING  STREET ADDRESS, CITY, STATE, ZIP  507 E FREMONT STREET BURGAW, NC 28425  ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN  A. BUILDING  FROM TOTAL TO THE STATE OF THE STATE	

**Electronically Signed** 

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE