CENTERS FOR MEDICARE & MEDICARD SERVICES OMB INC. 0988-03 MARLEN OF CORRECTION (1) DRAYLER SUPPLIER (2) MULTIPLE CONSTRUCTION (93) JOHT SUPRY COMPLETED MALE OF PROVIDER OR SUPPLIER 345520 (9) MUNO (1) DRAYLER SUPPLIER (2) MULTIPLE CONSTRUCTION (93) JOHT SUPRY COMPLETED (1) DRAYLER SUPPLIER (2) MULTIPLE CONSTRUCTION (93) JOHT SUPRY COMPLETED (2) MULTIPLE CONSTRUCTION (1) DRAYLER SUPPLIER (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CON	DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROV							
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 345520 B. WING C 01/27/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PELICAN HEALTH THOMASVILLE 1028 BLAIR STREET THOMASVILLE, NC 27360 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID F 000 INITIAL COMMENTS F 0 0 INITIAL COMMENTS A result of a	CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	NO. 0938-0391	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PELICAN HEALTH THOMASVILLE 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) (X5) COMPLETIO DATE F 000 INITIAL COMMENTS F 000 No deficiencies were cited as a result of a F 000							COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PELICAN HEALTH THOMASVILLE 1028 BLAIR STREET THOMASVILLE, NC 27360 1028 BLAIR STREET (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) (X5) COMPLETIO DATE F 000 INITIAL COMMENTS F 000 No deficiencies were cited as a result of a F 000			345520	B. WING				
PELICAN HEALTH THOMASVILLE THOMASVILLE, NC 27360 (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) (X5) COMPLETIO DATE F 000 INITIAL COMMENTS F 000 F 000								
THOMASVILLE, NC 27360 (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) (X5) COMPLETIO DATE F 000 INITIAL COMMENTS F 000 F 000 No deficiencies were cited as a result of a F 000 F 000					1028 BLAIR STREET			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIO DATE F 000 INITIAL COMMENTS F 000	PELICAN HEALTH THOMASVILLE				THOMASVILLE, NC 27360			
No deficiencies were cited as a result of a	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP	RECTIVE ACTION SHOULD BE COMPLETION RENCED TO THE APPROPRIATE DATE		
	F 000	INITIAL COMMENTS		F 000				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Electronically Signed 02/10/202			SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE 02/10/2020	

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.

PRINTED: 03/02/2020