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

PRINTED: 09/23/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ABBOTTS CREEK CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI		(X3) DATE SURVEY COMPLETED 09/17/2020		
ABBOTTS CREEK CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295		345333		B. WING _	B. WING			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments E 000 An unannounced COVID-19 Focused Survey was conducted on-site on 9/15/20 and continued off-site for record review and phone interviews through 9/17/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# OS0011.					877 HILL EVERHART ROAD			
An unannounced COVID-19 Focused Survey was conducted on-site on 9/15/20 and continued off-site for record review and phone interviews through 9/17/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# OS0011.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		(X5) COMPLETION DATE
was conducted on-site on 9/15/20 and continued off-site for record review and phone interviews through 9/17/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# OS0011.	E 000	Initial Comments		E	000			
An unannounced COVID-19 Focused Infection Control Survey was conducted on-site on 9/15/20 and continued off-site for record review and phone interviews through 9/17/20. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	F 000	was conducted on-soff-site for record rethrough 9/17/20. The compliance with 42 E-0024 (b)(6), Subp Term Care Facilities INITIAL COMMENT An unannounced C Control Survey was and continued off-siphone interviews through was found to be in confident of the CN Control and Prevent	oview and phone interviews the facility was found to be in CFR §483.73 related to art-B-Requirements for Long at Event ID# OS0011. S OVID-19 Focused Infection conducted on-site on 9/15/20 the for record review and rough 9/17/20. The facility compliance with 42 CFR control regulations and has MS and Centers for Disease tion (CDC) recommended	F	000			

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