POST-CERTIFICATION REVISIT REPORT

| | | (INITIALS) REVIEWED BY (INITIALS) | DATE | TITLE | | DATE | | |
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| | | | LSC | | LSC | | | |
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| | | Correction | ID Prefix | Correction | ID Prefix | | Correction | |
| | | | LSC | | LSC | | | |
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| | | 12/14/2020 | LSC | | LSC | | | |
| 483.15(0 | c)(7) | Completed | Reg. # | Completed | Reg. # | | Completed | |
| F0624 | | Correction | ID Prefix | Correction | ID Prefix | | Correction | |
| | | Y5 | Y4 | Y5 | Y4 | | DATE Y5 | |
| , to show d and the n number ey report | those of date su and the | eficiencies previously rep ich corrective action was identification prefix code | oorted on the CMS accomplished. E previously showi | s-2567, Statement of Deficiencies and deficiency should be fully idented on the CMS-2567 (prefix codes s | and Plan of Correction, tified using either the re hown to the left of each | , that have been egulation or LSC | | |
| CANOLINA REMAB CENTER OF CUMBERLAND | | | | FAYETTEVILLE, NC 28306 | | | | |
| NAME OF FACILITY | | | | | | | | |
| IDENTIFICATION NUMBER 345505 A. Building B. Wing | | | | | | _{Y2} 1/13/202 | 21 _{Y3} | |
| PROVIDER / SUPPLIER / CLIA / MULTIPLE CONS | | | | | | DATE OF | REVISIT | |
| | FO624 483.15(d | CATION NUMBER F FACILITY NA REHAB CEN ort is completed to the complete of t | ER / SUPPLIER / CLIA / CATION NUMBER | A. Building B. Wing FACILITY NA REHAB CENTER OF CUMBERLAND Ont is completed by a qualified State surveyor for the Medica, to show those deficiencies previously reported on the CMS d and the date such corrective action was accomplished. Ean number and the identification prefix code previously shown bey report form). TM DATE ITEM Y4 F0624 Correction ID Prefix Reg. # 12/14/2020 LSC Completed Reg. # LSC | RY SUPPLIER / CLIA / A Building B. Wing B. Wing B. Wing B. Wing STREET ADDRESS, 4600 CUMBERLAND FACILITY STREET ADDRESS, 4600 CUMBERLAND FAYETTEVILLE, NC: ort is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Labor, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies are reported on the CMS-2567, Statement of Deficiencies are reported on the CMS-2567 (prefix codes seen to corrective action was accomplished. Each deficiency should be fully iden on unmber and the identification prefix code previously shown on the CMS-2567 (prefix codes seen to complete the complete of the complete | MULTIPLE CONSTRUCTION A Building B Wing FACILITY NA REHAB CENTER OF CUMBERLAND STREET ADDRESS, CITY, STATE, ZIP CODE 4800 CUMBERLAND ROAD FAYETTEVILLE, NC 28306 ont is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Am to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction d and the date such corrective action was accomplished. Each deficiency should be fully identified using either the re normal property form). MM DATE ITEM YS YA DATE YS YA F0624 Correction ID Prefix Code previously shown on the CMS-2567 (prefix codes shown to the left of each ey report form). MM DATE ITEM YS YA PS YS YA F0624 Correction ID Prefix Completed Reg. # LSC Completed Reg. # LSC Completed Reg. # LSC Completed Reg. # LSC Correction ID Prefix Correction ID Prefix Completed Reg. # LSC Correction ID Prefix Correction ID Prefix Completed Reg. # LSC Correction ID Prefix Correction ID Prefix Completed Reg. # LSC Correction ID Prefix Correction ID Prefix Completed Reg. # LSC Correction ID Prefix Correction ID Prefix Completed Reg. # LSC Correction ID Prefix Correction ID Prefix Completed Reg. # LSC Correction ID Prefix Correction ID Prefix Completed Reg. # LSC Correction ID Prefix Correction ID Prefix Completed Reg. # LSC Correction ID Prefix Correction ID Prefix Completed Reg. # LSC Correction ID Prefix Correction ID Prefix Completed Reg. # LSC Correction ID Prefix Correction ID Prefix Completed Reg. # LSC Completed Reg. # LSC | A Building Wing STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CMBERILAND STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CMBERILAND ROAD FAYETTEVILLE, NC 283006 Dart is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been all and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC in unbrob and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on any report form). IM DATE ITEM Y4 Y5 Y4 ITEM Y4 Y5 Y6 Y4 Y5 Y6 Y4 Y5 Y6 Y4 Y5 Y6 | |