POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT		
IDENTIFICATION NUMBER	A. Building				
345404 _{Y1}	B. Wing	Y2	2/12/2021	Y3	
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
THREE RIVERS HEALTH AND RE	НАВ	1403 CONNER DRIVE			
		WINDSOR, NC 27983			

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).

ITE	м	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	F0641 483.20(g)	Correction Completed 02/08/2021	ID Prefix Reg. # LSC	F0686 483.25(b)(1)(i)(ii)	Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. # LSC		Completed	Reg. # LSC		Completed	Reg. # LSC		Completed
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC					
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC					
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
REVIEWED BY REVIEWED BY (INITIALS)		DATE	SIGNATURE OF	SURVEYOR		DATE		
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 1/11/2021				CK FOR ANY UNCORREC DRRECTED DEFICIENCIE				
Form CMS - 2567B (09/92) EF (11/06)				Page 1 of 1		EVENT	ID: YME812	