STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345574	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLAROSE NURSING AND REHAB	**200 BELLAROSE LAKE WAY GARNER, NC 27529**

(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) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation was conducted on 05/13/2024 through 05/16/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 6W8C11.	E 000		
F 000	INITIAL COMMENTS The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey). A recertification and complaint investigation survey was conducted from 05/13/2024 through 05/16/2024. Event ID# 6W8C11. The following intakes were investigated: NC00213360, NC00202985, and NC00201045. The following intakes were investigated NC00213360,NC00202985 and NC00201045 Please select one of the followings: [ ] __ of the __ complaint allegation(s) resulted in deficiency. [X] _7_ of the _7_ complaint allegations did not result in deficiency.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/29/2024