POST-CERTIFICATION REVISIT REPORT										
PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSTRUCTION								DATE OF REVISIT		
IDENTIFICATION NUMBER  A. Building							11/01/000	.4		
345365	Y1	B. Wing						Y2	11/21/202	.4 <sub>Y3</sub>
NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE							CODE			
SIGNATURE HEALTHCARE OF KINSTON 907 CUNNINGHAM ROAD										
KINSTON, NC 28501										
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).										
ITEM		DATE	ITEM			DATE				DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0554 483.10(c)(7)	Correction Completed	ID Prefix	F0582 483.10(g)(17)(18)(i)	-(v)	Correction	ID Prefix Reg. #	F0641 483.20(g)		Correction Completed
9. 11			1			Completed	1		`	op.otou