STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34A001

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

C 06/17/2011

NAME OF PROVIDER OR SUPPLIER

BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

932 OLD US 70 HIGHWAY
BLACK MOUNTAIN, NC 28711

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 000 INITIAL COMMENTS

No deficiencies cited as result of survey Event ID# KVMC11.

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete