DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAD SERVICES COMB NO. 0939-6039 CO2) MULTIPLE CONSTRUCTION A BULDING BUINNG CO2 MULTIPLE CONSTRUCTION A BULDING BUINNG CO3 MULTIPLE CONSTRUCTION CO3 MULTIPLE CONSTRUCTIO							PRINTED:	04/03/2012 APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER SUPPLIER (X2) MOETH LE SOUTH AND PLAN OF CORRECTION NUMBER:  A BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  543 MAPLE AVENUE  REIDSVILLE, NC 27320  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  No deficiencies were cited as a result of the complaint investigation on 4/2/12 EVENT ID#	DEPART	ARTMENT OF HEALTH AND HUMAN SERVICES						OMB NO. 0938-0391	
NAME OF PROVIDER OR SUPPLIER  AVANTE AT REIDSVILLE  STREET ADDRESS, CITY, STATE, ZIP CODE  543 MAPLE AVENUE  REIDSVILLE, NC 27320  (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 were cited as a result of the complaint investigation on 4/2/12 EVENT ID#	STATEMENT OF DEFICIENCIES		L/Y1\ PROVIDER/SUPPLIER/CLIA				COMPLETED		
AVANTE AT REIDSVILLE    Complete Control of		345227			NG		04/02/2012		
(X4) ID PREFIX TAG    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    F 000   INITIAL COMMENTS   F 000					543	3 MAPLE AVENUE			
No deficiencies were cited as a result of the complaint investigation on 4/2/12 EVENT ID#	(X4) ID PREFIX	SUMMARY STA	V MILIST BE PRECEDED BY FULL	PRE	∃X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD RE	COMPLETION	
complaint investigation on 4/2/12 EVENT ID#	F 000	INITIAL COMMEN	its	F	000				
		complaint investig	ere cited as a result of the ation on 4/2/12 EVENT ID#						
				And the state of t					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						TITLE		(X6) DATE	

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.