STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345550

B. WING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

DATE SURVEY COMPLETED

PRINTED: 05/11/2012

FORM APPROVED

OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

WHITE OAK OF WAXHAW

STREET ADDRESS, CITY, STATE, ZIP CODE

700 HOWIE MINE ROAD
WAXHAW, NC 28173

NAME OF PROVIDER OR SUPPLIER

MULTIPLE CONSTRUCTION

345550

05/02/2012

NAME OF PROVIDER OR SUPPLIER

WHITE OAK OF WAXHAW

STREET ADDRESS, CITY, STATE, ZIP CODE

700 HOWIE MINE ROAD
WAXHAW, NC 28173

NAME OF PROVIDER OR SUPPLIER

WHITE OAK OF WAXHAW

STREET ADDRESS, CITY, STATE, ZIP CODE

700 HOWIE MINE ROAD
WAXHAW, NC 28173

NAME OF PROVIDER OR SUPPLIER

WHITE OAK OF WAXHAW

STREET ADDRESS, CITY, STATE, ZIP CODE

700 HOWIE MINE ROAD
WAXHAW, NC 28173

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

ID PREFIX TAG

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of the complaint investigation. Event ID # 6Z4311

ID PREFIX TAG

F 000 PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

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

TITLE

(X4) ID PREFIX TAG

(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of the complaint investigation. Event ID # 6Z4311

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
Event ID: 6Z4311
Facility ID: 061191
If continuation sheet Page 1 of 1