STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345260

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
C 05/07/2014

NAME OF PROVIDER OR SUPPLIER
KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT

STREET ADDRESS, CITY, STATE, ZIP CODE
160 WINSTEAD AVE ROCKY MOUNT, NC  27804

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of the complaint investigation of 5/7/2014. Event ID# ONVF11. Intakes # NC00096493 and NC00096901.

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

Electronically Signed 05/19/2014

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.