(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345092

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

(X3) DATE SURVEY COMPLETED
C 06/18/2014

NAME OF PROVIDER OR SUPPLIER
WINSTON SALEM NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1900 W 1ST STREET
WINSTON-SALEM, NC  27104

(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

No deficiencies were cited as a result of the complaint investigation of 6/18/14. Event ID# POTS11.

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

Electronically Signed
07/01/2014

Laboratory Director's or Provider/Supplier Representative's Signature

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.