## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345211

**Date Survey Completed:** 03/25/2015

### Name of Provider or Supplier

**Riverpoint Crest Nursing and Rehabilitation Center**

**Street Address, City, State, Zip Code:**

2600 Old Cherry Point Road

New Bern, NC 28563

### Summary Statement of Deficiencies

**ID** **Prefix** **Tag** **Completion Date**

- **F 000** INITIAL COMMENTS

  The facility was found to be in compliance with the Medicare/Medicaid Long Term Care regulations, 42 CFR part 483, subpart B during the recertification survey of March 25, 2015.

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**Laboratory Director’s or Provider/Supplier Representative’s Signature**

Electronically Signed

03/30/2015

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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.