STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345081

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

(X3) DATE SURVEY COMPLETED
C 03/27/2015

NAME OF PROVIDER OR SUPPLIER

KINDRED TRANSITIONAL CARE & REHAB-ROSE MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE
4230 NORTH ROXBORO ROAD
DURHAM, NC  27704

(X4) ID PREFIX TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 000 INITIAL COMMENTS

There were no deficiencies as a result of the Complaint investigation survey completed on 3/27/15. Event ID#VWFN11. Complaint Intake #'s NC00105000 and NC00102111.

(X5) COMPLETION DATE

F 000

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

Electronically Signed 04/07/2015

TITLE

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:VWFN11 Facility ID: 923269
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