STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345173

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ________________
B. WING ______________________

(X3) DATE SURVEY COMPLETED

C 05/13/2015

NAME OF PROVIDER OR SUPPLIER

EMERALD HEALTH & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

54 RED MULBERRY WAY
LILLINGTON, NC 27546

(LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE) ETHEL L. WILSON

(TITLE) LABORATORY DIRECTOR

(X4) ID PREFIX TAG

(X5) COMPLETION DATE

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of the complaint investigation conducted on 05/13/15. Event ID# BVT211.

F 000

Electronically Signed

05/14/2015

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.