STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345384

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

(X3) DATE SURVEY COMPLETED
05/12/2016

NAME OF PROVIDER OR SUPPLIER
PRUITTHEATH-FARMVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
4351 SOUTH MAIN STREET
FARMVILLE, NC  27828

(X4) ID PREFIX TAG | (X4) ID PREFIX TAG | (X5) COMPLETION DATE
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F 000 | F 000 | 

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEEDED 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)
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F 000 INITIAL COMMENTS

The facility is in compliance with the requirement of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey).

No deficiencies were cited for the complaint investigation conducted on 05/12/16. Event ID #K0S811.

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.