STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345164

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _______________________

B. WING _______________________

(X3) DATE SURVEY COMPLETED

C 06/02/2016

NAME OF PROVIDER OR SUPPLIER

CHOWAN RIVER NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1341 PARADISE ROAD P O BOX 566
EDENTON, NC  27932

(X4) ID PREFIX TAG

IDENTIFICATION NUMBER:

345164

SUMMARY STATEMENT OF DEFICIENCIES

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

ID PREFIX TAG

ID PREFIX

TAG

F 000 INITIAL COMMENTS

No deficiencies were cites as a result of the complaint investigation survey of 6/2/16. Event ID # X7QQ11.

PROVIDER'S PLAN OF CORRECTION

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

(X5) COMPLETION DATE

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

Electronically Signed

06/21/2016

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.