A. BUILDING ________________________

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345144

B. WING _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

MULTIPLE CONSTRUCTION

DATE SURVEY COMPLETED

C 11/07/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER

PINE RIDGE HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

706 PINEYWOOD ROAD
THOMASVILLE, NC 27360

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

ID PREFIX TAG

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

ID PREFIX TAG

COMPLETION DATE

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of a complaint survey. Event ID # TYCD11.

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

ELECTRONICALLY SIGNED

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.