**Statement of Deficiencies and Plan of Correction**

**Name of Provider or Supplier:**
GREENDALE FOREST NURSING AND REHABILITATION CENTER

**Street Address, City, State, Zip Code:**
1304 SE SECOND STREET
SNOW HILL, NC  28580

---

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td></td>
<td>No deficiencies cited as a result of complaint investigation on 11/29/2016 Event GYZJ11.</td>
</tr>
</tbody>
</table>

**Laboratory Director's or Provider/Supplier Representative's Signature**

Electronically Signed

12/12/2016

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.