**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/CLIA Identification Number:** 345185

**Multiple Construction**

**A. Building**

**B. Wing**

**Date Survey Completed:** 02/17/2017

**Name of Provider or Supplier:** PREMIER LIVING AND REHAB CENTER

**Street Address, City, State, Zip Code:** 106 CAMERON STREET
LAKE WACCAMAW, NC  28450

**Summary Statement of Deficiencies**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey)</td>
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</tbody>
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**Laboratory Director's or Provider/Supplier Representative's Signature**

Electronically Signed: 02/22/2017

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.

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**Event ID:** JJDP11  
**Facility ID:** 923415  
**Printed:** 02/27/2017  
**Form Approved:** OMB NO. 0938-0391  
**If continuation sheet:** Page 1 of 1