STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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

(X3) DATE SURVEY COMPLETED

03/23/2017

NAME OF PROVIDER OR SUPPLIER

CENTRAL CONTINUING CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

1287 NEWSOME STREET
MOUNT AIRY, NC  27030

(X4) ID PREFIX TAG

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

(X5) COMPLETION DATE

F 000  INITIAL COMMENTS

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

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.

LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE  TITLE

Electronically Signed

03/31/2017