STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING ____________________________
B. WING ____________________________

NAME OF PROVIDER OR SUPPLIER
RIVER TRACE NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
250 LOVERS LANE
WASHINGTON, NC 27889

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

No deficiencies were cited as a result of the complaint investigation survey. Event ID #ESYL11.

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

Electronically Signed
12/29/2017

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.