STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:
345092

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

(X3) DATE SURVEY COMPLETED
03/07/2018

NAME OF PROVIDER OR SUPPLIER
WINSTON SALEM NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1900 W 1ST STREET
WINSTON-SALEM, NC 27104

(X4) ID PREFIX TAG

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

F 000  INITIAL COMMENTS

No deficiencies were cited as a result of this
complaint investigation conducted on 3/7/2018
Event ID # GU4H11

F 000

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

Electronically Signed
03/07/2018

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.