STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345380

(X2) MULTIPLE CONSTRUCTION
A. BUILDING __________________________
B. WING ____________________________

(X3) DATE SURVEY COMPLETED
R
07/27/2018

NAME OF PROVIDER OR SUPPLIER

VILLAGE GREEN HEALTH AND REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE
1601 PURDUE DRIVE
FAYETTEVILLE, NC 28304

(X4) ID PREFIX TAG

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

ID PREFIX TAG

PROVIDER’S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

(F 000) INITIAL COMMENTS
A revisit was conducted on 07/27/18 and the facility is back into compliance effective 07/06/18.

(F 000)

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

Electronically Signed

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.