**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/CLIA Identification Number:** 345479

**Multiple Construction Wing:** _____________________________

**Department of Health and Human Services**
**Centers for Medicare & Medicaid Services**

**Name of Provider or Supplier:** SALEMTOWNE  
**Street Address, City, State, Zip Code:** 5101 INDIANA AVENUE, SALEM, NC  27106

**Initial Comments:**

No deficiencies were cited as a result of the complaint investigation survey ending 10/31/18. Event #JZES11.

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.