# Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER**

Curis at Reidsville Transitional Care & Rehab CNTR

**STREET ADDRESS, CITY, STATE, ZIP CODE**

543 Maple Avenue
Reidsville, NC  27320

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<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
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</tbody>
</table>

There was no deficiency cited as result of complaint investigation, Event ID 94S811, 10/26/18

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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.

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Electronically Signed

10/31/2018

Laboratory Director's or Provider/Supplier Representative's Signature:  

Title:  

X(X) Date:  

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Event ID: 94S811  
Facility ID: 923322  
If continuation sheet Page 1 of 1