STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING _____________________________

B. WING _____________________________

C. WING _____________________________

NAME OF PROVIDER OR SUPPLIER

CURIS AT CONCORD NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

515 LAKE CONCORD ROAD NE
CONCORD, NC 28025

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000 INITIAL COMMENTS

There were no deficiencies cited as a result of this complaint investigation survey of 12/12/18. Event ID #F1CG11.

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

Electronically Signed 12/26/2018

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.