STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345500

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

(X3) DATE SURVEY COMPLETED
06/12/2019

NAME OF PROVIDER OR SUPPLIER
WINDSOR POINT CONTINUING CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
1221 BROAD STREET
FUQUAY VARINA, NC  27526

(X4) ID PREFIX TAG

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

E 000 Initial Comments

The facility was found to be in compliance with 42 C.F.R. 483.73, emergency preparedness. Event ID UM2011.

F 000 INITIAL COMMENTS

The facility is in compliance with the requirements of 42 C.F.R. Part 483, Subpart B for Long Term Care Facilities (General Health Survey). .

(X5) COMPLETION DATE

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

Electronically Signed
07/02/2019

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.