On 09/11/2019 the Division of Health Service Regulation, Nursing Home Section conducted an on-site revisit and complaint investigation survey. There were a total of 26 allegations investigated. None of the allegations were substantiated. Event ID# ETIF11.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(A) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345129

(B) MULTIPLE CONSTRUCTION

A. BUILDING __________________________

B. WING __________________________

(C) DATE SURVEY COMPLETED

R-C

09/11/2019

**NAME OF PROVIDER OR SUPPLIER**

DAVIE NURSING AND REHABILITATION CENTER

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

498 MADISON ROAD

MOCKSVILLE, NC 27028

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**OMB NO. 0938-0391**

**PRINTED:** 09/17/2019

**FORM APPROVED:**

**electronically Signed**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F000</td>
<td>INITIAL COMMENTS</td>
<td>F000</td>
<td>On 09/11/2019, The Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted an on-site revisit and complaint investigation survey. The facility is back into compliance effective 08/27/19. Event ID# BSA112.</td>
<td></td>
<td></td>
<td></td>
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</table>

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.

**LUMA LATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**TITLE**

**DATE**

Form CMS-2567(02-99) Previous Versions Obsolete

Event ID: BSA112

Facility ID: 922953

If continuation sheet Page 1 of 1