STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345215

(X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:
A. BUILDING ____________________________
B. WING ____________________________

(X3) DATE SURVEY COMPLETED
R-C
09/13/2019

NAME OF PROVIDER OR SUPPLIER
RIVER TRACE NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
250 LOVERS LANE
WASHINGTON, NC  27889

(X4) ID PREFIX TAG

(X5) COMPLETION DATE

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

ID PREFIX TAG

PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000 INITIAL COMMENTS

An onsite follow up survey was completed on 09-12-19 through 09-13-19. The facility was back in compliance effective 08/30/19. Event ID# QISF12.

F 000

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

Electronically Signed
09/19/2019

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.