## Statement of Deficiencies and Plan of Correction

### Name of Provider or Supplier

GREENDALE FOREST NURSING AND REHABILITATION CENTER

### Street Address, City, State, Zip Code

1304 SE SECOND STREET
SNOW HILL, NC 28580

### Provider/Supplier/CLIA Identification Number

345366

### Date Survey Completed

03/12/2020

### Summary Statement of Deficiencies

**F 000 INITIAL COMMENTS**

A complaint investigation for Intake #'s NC00161530, NC00160868, NC00157919 and NC00157740 was conducted on 03/10/20 through 03/12/20, Event ID# 7YKE11. All of the ten allegations were unsubstantiated.

### Provider's Plan of Correction

Each corrective action should be cross-referenced to the appropriate deficiency.

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

Electronically Signed

03/30/2020

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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.