STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345288

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

(X3) DATE SURVEY COMPLETED
04/22/2020

NAME OF PROVIDER OR SUPPLIER
COMPASS HEALTHCARE AND REHAB ROWAN, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
1404 S SALISBURY AVENUE
SPENCER, NC 28159

E 000 Initial Comments
An unannounced COVID-19 Focused Survey was conducted 4/22/2020. The facility was found to be in compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID # IV0C11.

F 000 INITIAL COMMENTS
An unannounced COVID-19 Focused Survey was conducted 4/22/2020. The facility was found to be in compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID # IV0C11.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed
04/30/2020

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.