# Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345404

**Multiple Construction B. Wing:** __________

**Date Survey Completed:** 05/18/2020

**Name of Provider or Supplier:**

**Three Rivers Health and Rehab**

**Street Address, City, State, Zip Code:**

1403 Conner Drive
Windsor, NC 27983

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<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td>E 000</td>
<td>An unannounced COVID-19 Focused Survey was conducted on 5/18/20. The facility was found in Compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID# VTCP11.</td>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>An unannounced COVID-19 Focused Survey was conducted on 5/18/20. Event ID VTCP11.</td>
</tr>
</tbody>
</table>

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**Laboratory Director's or Provider/Supplier Representative's Signature:**

**Title:**

Electronically Signed 05/21/2020

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.