**A. BUILDING**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

345161

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DATE SURVEY COMPLETED:** 06/05/2020

**MULTIPLE CONSTRUCTION B. WING**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**OMB NO. 0938-0391**

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

102 LEONARD AVENUE

ABERNETHY LAURELS

NEWTON, NC 28658

**NAME OF PROVIDER OR SUPPLIER**

**SUMMARY STATEMENT OF DEFICIENCIES**

**ID**

**PREFIX**

**TAG**

**PRELIMINARY STATEMENT OF DEFICIENCIES**

**ID**

**PREFIX**

**TAG**

**E 000**

Initial Comments

An unannounced COVID-19 Focused Survey was conducted on 06/03/2020-06/05/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# COVK11

**F 000**

INITIAL COMMENTS

An unannounced COVID-19 Focused Infection Control Survey was conducted on 06/03/2020-06/05/2020. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# COVK11.

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**TITLE**

Electronically Signed

06/19/2020

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.