**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING ________________________**

**B. WING _____________________________**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**NAME OF PROVIDER OR SUPPLIER**

**AYDEN COURT NURSING AND REHABILITATION CENTER**

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

128 SNOW HILL ROAD
AYDEN, NC  28513

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<td>E 000</td>
<td>Initial Comments</td>
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<td>F 000</td>
<td>INITIAL COMMENTS</td>
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**E 000 Initial Comments**

An unannounced COVID-19 Focused Survey was conducted on 7/23/2020. The facility was found to be in compliance with 42 CFR §73. related to E-0024 (bX6). Subpart-B-Requirements for Long term Care facilities. Event ID # B2H711.

**F 000 INITIAL COMMENTS**

An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 7/23/2020 through 7/24/2020. The facility was found to be 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# B2H711.

5 of the 5 allegations were not substantiated.

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

**TITLE**

**DATE**

Electronically Signed

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.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

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