A. BUILDING _____________________________ (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345190

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED 10/13/2020

NAME OF PROVIDER OR SUPPLIER

MURPHY REHABILITATION & NURSING

STREET ADDRESS, CITY, STATE, ZIP CODE

3992 EAST US HWY 64 ALT

MURPHY, NC  28906

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

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

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

E 000 Initial Comments E 000

An unannounced COVID-19 Focused Survey was conducted on 10/13/2020. 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# 8YK611.

F 000 INITIAL COMMENTS F 000

An unannounced COVID-19 Focused Infection Control Survey was conducted on 10/13/2020. 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# 8YK611.

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

Electronically Signed

10/14/2020

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.

 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 8YK611 Facility ID: 943366 If continuation sheet Page 1 of 1