A. BUILDING ______________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345516

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

11/17/2020

NAME OF PROVIDER OR SUPPLIER

CONOVER NURSING AND REHAB CTR

STREET ADDRESS, CITY, STATE, ZIP CODE

920 4TH STREET SOUTHWEST
CONOVER, NC  28613

PROVIDER'S PLAN OF CORRECTION

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

(ID PREFIX) TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(ID PREFIX) TAG

COMPLETION DATE

E 000 Initial Comments

An unannounced COVID-19 Focused Survey was conducted on 11/17/20. 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# 2H7I11.

F 000 INITIAL COMMENTS

An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 11/17/20. 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. Four of the four complaint allegations were unsubstantiated. Event ID#: 2H7I11

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

Electronically Signed

11/24/2020

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.