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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345194

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____________________________
B. WING ____________________________

(X3) DATE SURVEY COMPLETED
C 12/03/2020

NAME OF PROVIDER OR SUPPLIER
GLENFLORA

STREET ADDRESS, CITY, STATE, ZIP CODE
5701 FAYETTEVILLE ROAD
LUMBERTON, NC 28360

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X4) ID PREFIX TAG
E 000 Initial Comments
F 000 INITIAL COMMENTS

E 000

An unannounced COVID-19 Focused Emergency Preparedness Survey was conducted onsite 12/2/20 and remotely through 12/3/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID # 6HPC11.

F 000

An unannounced COVID-19 Focused Infection Control Survey and Complaint Investigation was conducted onsite 12/2/20 and remotely through 12/3/20. 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. One of one complaint allegations was unsubstantiated. Event ID # 6HPC11.

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

Electronically Signed
12/07/2020

(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.