STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION
(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:
345039

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

(X3) DATE SURVEY
COMPLETED
R-C
03/19/2021

NAME OF PROVIDER OR SUPPLIER
SUMMERSTONE HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
485 VETERANS WAY
KERNERSVILLE, NC  27284

(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

(F 000) INITIAL COMMENTS
A desk review was conducted on 3/19/21, and
the facility is back in compliance as of 2/19/21

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

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.