STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345348

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ____________________________
B. WING ____________________________

(X3) DATE SURVEY COMPLETED

C 03/31/2021

NAME OF PROVIDER OR SUPPLIER

WHISPERING PINES NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

523 COUNTRY CLUB DRIVE
FAYETTEVILLE, NC 28301

345348 03/31/2021

F 000 INITIAL COMMENTS

An unannounced complaint investigation survey was conducted from 03/30/2021 through 03/31/2021. Event ID# FD8J11.

2 of the 2 complaint allegations were not substantiated.

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.

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

Electronically Signed 04/22/2021

FORM CMS-2567(02-99) Previous Versions Obsolete