

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 345407 Y1	MULTIPLE CONSTRUCTION A. Building _____ B. Wing _____	DATE OF REVISIT 5/12/2021 Y2
NAME OF FACILITY CROSS CREEK HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 QUARTER ROAD SWANQUARTER, NC 27885	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 483.12(c)(1)(4)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	04/09/2021	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) _____	DATE _____	SIGNATURE OF SURVEYOR _____	DATE _____
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS) _____	DATE _____	TITLE _____	DATE _____
FOLLOWUP TO SURVEY COMPLETED ON 3/29/2021		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		
		<input type="checkbox"/> YES <input type="checkbox"/> NO		