A. BUILDING _____________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345177

(X2) MULTIPLE CONSTRUCTION B. WING _____________________________

(X3) DATE SURVEY COMPLETED

R-C 05/18/2021

NAME OF PROVIDER OR SUPPLIER

THE GREENS AT PINEHURST REHAB & LIVING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

205 RATTLESNAKE TRAIL

PINEHURST, NC 28374

PROVIDER'S PLAN OF CORRECTION

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

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 000 INITIAL COMMENTS

A desk review follow up recertification and complaint survey dated 3/11/21 was conducted on 5/17/21 and 5/18/21. The facility was found in compliance with regulatory areas affected on 4/8/21.

F 000

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.