**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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

345164

**A. BUILDING ____________________________**

**NAME OF PROVIDER OR SUPPLIER**

CHOWAN RIVER NURSING AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1341 PARADISE ROAD

EDENTON, NC  27932

**B. WING _____________________________**

**DATE SURVEY COMPLETED**

R-C

06/16/2021

**F 000 INITIAL COMMENTS**

An onsite revisit was conducted on 6/16/2021 and the facility is back into compliance effective 6/1/2021. The directed plan of correction including the root cause analysis were reviewed.

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

Electronically Signed

**TITLE**

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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.