DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES  

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  
345289

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

(X3) DATE SURVEY COMPLETED  
C 02/24/2022

NAME OF PROVIDER OR SUPPLIER  
CURRITUCK HEALTH & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE  
3907 CARATOKE HIGHWAY  
BARCO, NC 27917

(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

<table>
<thead>
<tr>
<th>E 000</th>
<th>Initial Comments</th>
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<tbody>
<tr>
<td></td>
<td>An unannounced Recertification survey was conducted from 02/21/22 through 02/24/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #7X2W11.</td>
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<tr>
<th>F 000</th>
<th>INITIAL COMMENTS</th>
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<tbody>
<tr>
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<td>A complaint and recertification survey was conducted from 02/21/22 through 02/24/22. Event ID #7X2W11.</td>
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<td>The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey).</td>
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<td>5 of the 5 complaint allegations were not substantiated.</td>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
Electronically Signed  
02/28/2022

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.

FORM CMS-2567(02-99) Previous Versions Obsolete  
Event ID: 7X2W11  
Facility ID: 923450  
If continuation sheet Page 1 of 1