CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE S COMPL A. BUILDING F	LETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPL 345301 B. WING 04/2 NAME OF PROVIDER OR SUPPLIER WHITE OAK MANOR - BURLINGTON (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 323 BALDWIN ROAD BURLINGTON, NC 27217 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPL	LETED 20/2022 (X5) COMPLETION
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F 000 INITIAL COMMENTS F 000	
A paper revisit was conducted on 4/20/22. The facility is in compliance as of 3/25/22	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE	(X6) DATE

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.

PRINTED: 04/20/2022