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

PRINTED: 08/23/2023 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 2211 BISHOPS WAY LANE CARREST	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
MANE OF PROVIDER OR SUPPLIER ASBURY HEALTH AND REHABILITATION CENTER (PALID SUMMARY STATEMENT OF DEPICIENCES CHARLOTTE, NO. 26215 (PALID SUMMARY STATEMENT OF DEPICIENCES CACAL DEPOCHAGE OF FLUI. RECOULATION OF U.SC. DENTIFYING INFORMATION) FOOD INITIAL COMMENTS An unannounced complaint investigation was conducted 7/28/23 through 7/27/73. Event ID# E4EC1.1. The following intake was investigated NC000204220. Two of the two complaint allegations did not result in deficiency.			345544					
ASBURY HEALTH AND REMABILITATION CENTER CHARLOTTE, NC. 28218						DE	1 077	2112023
CHARLOTE A 28215 CHARLOTE A					3211 BISHOPS WAY LANE			
PREFIX (EACH DEFICIENCY MIST BE PRECIDED BY TRILL REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS An unannounced complaint investigation was conducted 7/28/23 through 7/27/23. Event ID# E4EC11. The following intake was investigated NC00204220. Two of the two complaint allegationsdid not result in deficiency.	ASBURT HEALTH AND REHABILITATION CENTER				CHARLOTTE, NC 28215			
An unannounced complaint investigation was conducted 7/26/23 through 7/27/23. Event ID# E4EC11. The following intake was investigated NC00204220. Two of the two complaint allegationsdid not result in deficiency.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
conducted 7/26/23 through 7/27/23. Event ID# E4EC11. The following intake was investigated NC00204220. Two of the two complaint allegationsdid not result in deficiency.	F 000	0 INITIAL COMMENTS		F	000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		conducted 7/26/23 th E4EC11. The followin NC00204220. Two of	rough 7/27/23. Event ID# ng intake was investigated f the two complaint					

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.

Electronically Signed

08/17/2023