		POST	-CERT	IFICATION	REVISIT	REPORT			
	R / SUPPLIER / CLIA /	MULTIPLE CONS	TRUCTION					DATE OF REVISIT	
IDENTIFICATION NUMBER A. Building B. Wing								9/19/2023	
11 0				1			Y2	07.1072020	Y3
NAME OF FACILITY KERR LAKE NURSING AND REHABILITATION CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE				
KERR LA	AKE NURSING AND REF	HABILITATION CE	ENIER	1245 PARK AVENUE HENDERSON, NC 27536					
				l	TIENDERCON, NO 27				
program, corrected provision	ort is completed by a qual to show those deficienci d and the date such corre number and the identific ey report form).	es previously rep ctive action was a	orted on the accomplishe	CMS-2567, Statem d. Each deficiency	ent of Deficiencies a should be fully ident	nd Plan of Co fied using eith	rection, that have er the regulation o	been or LSC	
ITEM		DATE ITEM			DATE ITEM			DATE	
Y4		Y5	Y4		Y5	Y4		Y5	
ID Prefix	F0578	Correction	ID Prefix	F0580	Correction	ID Prefix	F0690	Correc	tion
Reg.#	483.10(c)(6)(8)(g)(12)(i)- (v)	Completed	Reg.#	483.10(g)(14)(i)-(iv)(15) Completed	Reg. #	483.25(e)(1)-(3)	Comple	eted
LSC		09/13/2023	LSC		09/13/2023	LSC		09/13/20	023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correc	tion
Reg.#		Completed	Reg.#		Completed	Reg. #		Comple	eted
LSC			LSC			LSC			
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Reg.#		Completed	Reg.#		Completed	Reg. #		Comple	eted
LSC		_	LSC			LSC			
			ľ						

REVIEWED BY REVIEWED BY DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) DATE TITLE DATE **REVIEWED BY** REVIEWED BY CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON

ID Prefix

Reg.#

LSC

Correction

Completed

Form CMS - 2567B (09/92) EF (11/06)

ID Prefix

Reg. #

8/23/2023

LSC

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EVENT ID:

ID Prefix

Reg. #

LSC

Correction

Completed

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

44G212

YES NO

Correction

Completed