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

PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED
	345528		B. WING			C <b>08/16/2023</b>
NAME OF PROVIDER OR SUPPLIER  RIVER LANDING AT SANDY RIDGE				STREET ADDRESS, CITY, STATE, ZIP CODE  1575 JOHN KNOX DRIVE  COLFAX, NC 27235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)	
E 000	Initial Comments		E	000		
F 000	survey was conducte 8/16/23. The facility		F	000		
	survey was conducte 8/16/23. Event ID# 6 was investigated NC	complaint investigation ed from 8/13/23 through SCLB11. The following intake c00202310.				
	deficiency.					
I ABORATORY I	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUI	RF	TITLE		(X6) DATE

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** 

08/30/2023