## **POST-CERTIFICATION REVISIT REPORT**

|                       | MULTIPLE CONSTRUCTION |                                       | DATE OF REVISIT |    |
|-----------------------|-----------------------|---------------------------------------|-----------------|----|
| IDENTIFICATION NUMBER | A. Building           |                                       |                 |    |
| 345479 <sub>Y1</sub>  | B. Wing               | Y2                                    | 10/23/2024      | Y3 |
| NAME OF FACILITY      |                       | STREET ADDRESS, CITY, STATE, ZIP CODE |                 |    |
| SALEMTOWNE            |                       | 1550 BABCOCK DRIVE                    |                 |    |
|                       |                       | WINSTON SALEM, NC 27106               |                 |    |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| ITEM DATE                                    |                 | ITEM   |           | DATE            | ITEM       |           | DATE |            |
|--|-----------------|--|-----------|-----------------|------------|-----------|------|------------|
| Y4 Y5  |                 | Y4   |           | Y5              | Y4         |           | Y5   |            |
| ID Prefix                                    | F0812           | Correction   | ID Prefix |                 | Correction | ID Prefix |      | Correction |
| Reg. #                                       | 483.60(i)(1)(2) | Completed  | Reg. #    |                 | Completed  | Reg. #    |      | Completed  |
| LSC  |                 | 10/18/2024   |           |                 |            |           |      |            |
| ID Prefix                                    |                 | Correction   | ID Prefix |                 | Correction | ID Prefix |      | Correction |
| Reg. #                                       |                 | Completed  | Reg. #    |                 | Completed  | Reg. #    |      | Completed  |
| LSC  |                 |  |           |                 | -          | LSC       |      |            |
| ID Prefix                                    |                 | Correction   | ID Prefix |                 | Correction | ID Prefix |      | Correction |
| Reg. #                                       |                 | Completed  | Reg. #    |                 | Completed  | Reg. #    |      | Completed  |
| LSC  |                 |  | LSC       |                 | -          |           |      |            |
| ID Prefix                                    |                 | Correction   | ID Prefix |                 | Correction | ID Prefix |      | Correction |
| Reg. #                                       |                 | Completed  | Reg. #    |                 | Completed  | Reg. #    |      | Completed  |
| LSC  |                 |  | LSC       |                 | -          | LSC       |      |            |
| ID Prefix                                    |                 | Correction   | ID Prefix |                 | Correction | ID Prefix |      | Correction |
| Reg. #                                       |                 | Completed  | Reg. #    |                 | Completed  | Reg. #    |      | Completed  |
| LSC  |                 |  | LSC       |                 | -          | LSC       |      |            |
| REVIEWE<br>STATE AG                          |                 | REVIEWED BY<br>(INITIALS)  | DATE      | SIGNATURE OF SU | JRVEYOR    | I         | DATE |            |
| REVIEWE<br>CMS RO                            | D BY            | REVIEWED BY<br>(INITIALS)  | DATE      | TITLE           |            |           | DATE |            |
| FOLLOWUP TO SURVEY COMPLETED ON<br>9/12/2024 |                 | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |           |                 |            |           |      |            |