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POST-CERTIFICATION REVISIT REPORT									
PROVIDE	PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSTRUCTION							DATE OF REVISIT	
	CATION NUMBER	A. Building						E/00/000E	
345292	Y1	B. Wing					Y2	5/29/2025	Y3
NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE							CODE		
GRANTSBROOK NURSING AND REHABILITATION CENTER 290 KEEL ROA					290 KEEL ROAD				
GRANTSBORO, NC 28529									
provision	I and the date such correct number and the identificate report form).		•	,	•	•	•		
ITEM		DATE	ITEM		DATE	ITEM		DATE	
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	F0656	Correction	ID Prefix	F0806	Correction	ID Prefix	F0880	Co	orrection
Reg.#	483.21(b)(1)(3)	Completed	Reg. #	483.60(d)(4)(5)	Completed	Reg. #	483.80(a)(1)(2)(4)(e)(f) Co	ompleted
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