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

PRINTED: 06/24/2025 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 FORHALL ROAD NEWPORT, NC. 2870	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER CROATAN RIDGE NURSING AND REHABILITATION CENTER (A) DESCRIPTION OF THE PROVIDER			245494				
CROATAN RIDGE NURSING AND REHABILITATION CENTER 210 FOXHALL ROAD NEWPORT, NC 28708 SUMMARY STATEMENT OF DEPICIENCIES PRETIX REGULATORY OR LISC IDENTIFYING INFORMATION) TAG PROPERTY ACC PREFIX TAG CROSS-REFERENCE TO THE APPROPRIATE CONFIDENCE CROSS-REFERENCE TO THE APPROPRIATE CONFIDENCE CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APP			343431	D. WING			06/10/2025
NewPort, No. 28570	NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZII	P CODE		
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			ation did not result in a				

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

D6/20/2025

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.