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

PRINTED: 07/02/2019 FORM APPROVED OMB NO. 0938-0391

MANUE OF PROVIDER OR SUPPLIER SCHAASH HOUSE II SUMMARY STATEMENT OF DETICIENCES PRETX 1AG SUMMARY STATEMENT OF DETICIENCES PRILL RECHLARORY MUST RE PRECEDED BY FIEL TAG PRETX 1AG INITIAL COMMENTS THIS FACILITY IS IN COMPLIANCE WITH THE CONDITIONS OF PARTICIPATION FOR INITERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES FOUNDAT 42 CFR 483.480 (GENERAL/HEALTH REQUIREMENTS).	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER SCI-NASH HOUSE II (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 000 INITIAL COMMENTS THIS FACILITY IS IN COMPLIANCE WITH THE CONDITIONS OF PARTICIPATION FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES FOUND AT 42 CFR 483.480 STREET ADDRESS, CITY, STATE, ZIP CODE 3505 HAWTHORNE RD ROCKY MOUNT, NC 27803 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 000 W 000 W 000 THIS FACILITY IS IN COMPLIANCE WITH THE CONDITIONS OF PARTICIPATION FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES FOUND AT 42 CFR 483.480			34G187	B. WING _	WING		07/02/2019	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 000 INITIAL COMMENTS THIS FACILITY IS IN COMPLIANCE WITH THE CONDITIONS OF PARTICIPATION FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES FOUND AT 42 CFR 483.400 THROUGH 483.460 AND 42 CFR 483.480					3505 HAWTHORNE RD	DE		
THIS FACILITY IS IN COMPLIANCE WITH THE CONDITIONS OF PARTICIPATION FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES FOUND AT 42 CFR 483.400 THROUGH 483.460 AND 42 CFR 483.480	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		THIS FACILITY IS IN CONDITIONS OF PAINTERMEDIATE CAFINDIVIDUALS WITH DISABILITIES FOUN THROUGH 483.460 / (GENERAL/HEALTH	I COMPLIANCE WITH THE RTICIPATION FOR RE FACILITIES FOR INTELLECTUAL D AT 42 CFR 483.400 AND 42 CFR 483.480 REQUIREMENTS).					

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

(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.

Facility ID: 922520