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

PRINTED: 08/26/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER RIVERBEND SUMMARY STATEMENT OF DEFICIENCIES (MACH DISTRICTIVE (MACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PRETEX (MACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PRETEX (MACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PROVIDERS PLAN OF CORRECTION ACAID BE CENTRY MO SINCHMATION) W 000 INITIAL COMMENTS A complaint survey was completed on 8/26/20 for complaint was unsubstantiated and no deficiencies were cited.	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 RIVERBEND STREET ADDRESS, CITY, STATE, ZIP CODE 140 PIRATES ROAD NEW BERN, NC 28562 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A complaint survey was completed on 8/26/20 for complaint intake# NC00168622. The complaint was unsubstantiated and no deficiencies were						·		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 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.