DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE						
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03						
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
34G037		B. WING		C 05/05/2021		
NAME OF PROVIDER OR SUPPLIER						
MALLARD LANE CENTER			142 MALLARD LANE ROCKINGHAM, NC 28379			
D SUMMARY STATEMENT OF DEFICIENCIES IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOULD	LD BE COMPLÉTION		
00 INITIAL COMMENTS		W 0	000			
on 5/5//21. Deficie result of the compla	ncies were not cited as a aint and follow up survey for					
					(X6) DATE	
	RS FOR MEDICARE	RS FOR MEDICARE & MEDICAID SERVICES     IOF DEFICIENCIES     IOF DEFICIENCIES     IDENTIFICATION NUMBER:     IDENTIFICATION NUMBER:     IDENTIFICATION NUMBER:     SUMMARY STATEMENT OF DEFICIENCIES     (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     INITIAL COMMENTS     A follow up and complaint survey was conducted on 5/5//21. Deficiencies were not cited as a result of the complaint and follow up survey for Intake #NC00176216.	RS FOR MEDICARE & MEDICAID SERVICES     OF DEFICIENCIES F CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   (X2) MUL A. BUILD     34G037   B. WING     PROVIDER OR SUPPLIER   B. WING     CD LANE CENTER   ID     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID     INITIAL COMMENTS   W C     A follow up and complaint survey was conducted on 5/5//21. Deficiencies were not cited as a result of the complaint and follow up survey for   W C	IMENT OF HEALTH AND HUMAN SERVICES O   SE FOR MEDICARE & MEDICAD SERVICES O   OF DEFICIENCIES (X1) PROVIDER/SUPPLER/CLIA DENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING O   PROVIDER OR SUPPLIER 346037 B WING   STROMEDER OR SUPPLIER 346037 B WING   SUMMARY STATEMENT OF DEFICIENCIES (EACH ORFCIPENCY MUST EFFRECEDED BY FULL REGULATORY ON LSC DENTIFYING INFORMATION) PRETX TAS CROSS-REFERENCE OF ORECTON (CROSS-REFERENCE)   INITIAL COMMENTS W 000 V000 PRETX PREVIDENCY MUST EFFRECEDED BY FULL (CROSS-REFERENCE)   A follow up and complaint survey was conducted on 5/5/J21. Deficiencies were not cited as a result of the complaint and follow up survey for Intake #NC00176216. W 000	IMENT OF HEALTH AND HUMAN SERVICES PORME NO.   SFOR MEDICARE & MEDICALD SERVICES OMB NO.   OF DEFICIENCIES (X) PROVIDERSUPPLIERCLA DEMTIFICATION NUMBER (X) OT A BUILDING   34G037 B. WING (X) PROVIDERSUPPLIERCLA BUILDING (X) OT A BUILDING   TROVIDER SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 142 MALLARD LANE ROCKINGHAM, NC 28379   SUMMARY STATEMENT OF DEFICIENCIES (RECH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC DENTFRYING INFORMATION) ID PREFX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ADTION SHOULD BE CROSS-REPERINCE TO THE APPROPRIATE DEFICIENCY)   INITIAL COMMENTS W 000   A follow up and complaint survey was conducted on 55/5/21. Deficiencies were not cited as a result of the complaint and follow up survey for Intake #NC00176216. W 000	

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.

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