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

PRINTED: 08/16/2013 FORM APPROVED OMB NO. 0938-0391

FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
0.470.47					С	
					08/06/2013	
PREMIER NURSING AND REHABILITATION CENTER			JACKSONVILLE, NC 28546			
SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOU		BE	(X5) COMPLETION DATE
00 INITIAL COMMENTS		F 000				
No deficiencies were cited for Event ID FNSL11.						
Y DIRECTOR'S OR PROVID	DER <i>i</i> stippi ier representative's sigi	VATURE		TITI F		(X6) DATE
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT No deficiencies we	PROVIDER OR SUPPLIER R NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies were cited for Event ID FNSL11.	PROVIDER OR SUPPLIER R NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies were cited for Event ID FNSL11.	DENTIFICATION NUMBER: 345217 PROVIDER OR SUPPLIER R NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies were cited for Event ID FNSL11.	A BUILDING 345217 B. WING PROVIDER OR SUPPLIER R NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE ST JACKSONVILLE, NC 28546 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPR	A BUILDING 345217 B. WING ROUNDER OR SUPPLIER R NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies were cited for Event ID FNSL11.

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.