

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

PRINTED: 02/17/2021  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                               |                                                                                                                                                                                                                                                                          |                                                                         |                                                                                                                 |                      |                                                                 |
|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>345045</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                            |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/22/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE FOLEY CENTER AT CHESTNUT RIDGE</b> |                                                                                                                                                                                                                                                                          |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>621 CHESTNUT RIDGE PARKWAY</b><br><b>BLOWING ROCK, NC 28605</b>     |                      |                                                                 |
| (X4) ID PREFIX TAG                                                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                   | ID PREFIX TAG                                                           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |                                                                 |
| F 000                                                                         | INITIAL COMMENTS<br><br>A complaint investigation survey was conducted on 01/20/21 with additional information obtained through 01/22/21 therefore the exit date was changed to 01/22/21. Four of the four complaint allegations were unsubstantiated. Event ID #0RC811. | F 000                                                                   |                                                                                                                 |                      |                                                                 |

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

TITLE

(X6) DATE

Electronically Signed

02/07/2021

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.