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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER<br>345520   Y1 | MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   Y2 | DATE OF REVISIT<br>5/28/2019   Y3 |
|---|---|---|
| NAME OF FACILITY<br>CURIS AT THOMASVILLE TRANSITIONAL CARE & REHAB | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1028 BLAIR STREET<br>THOMASVILLE, NC 27360 | |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| ITEM<br>Y4 | DATE<br>Y5 | ITEM<br>Y4 | DATE<br>Y5 | ITEM<br>Y4 | DATE<br>Y5 |
|---|---|---|---|---|---|
| ID Prefix F0641<br>Reg. # 483.20(g)<br>LSC | Correction<br>Completed<br>05/18/2019 | ID Prefix F0657<br>Reg. # 483.21(b)(2)(i)-(iii)<br>LSC | Correction<br>Completed<br>05/18/2019 | ID Prefix F0658<br>Reg. # 483.21(b)(3)(i)<br>LSC | Correction<br>Completed<br>05/18/2019 |
| ID Prefix F0686<br>Reg. # 483.25(b)(1)(i)(ii)<br>LSC | Correction<br>Completed<br>05/18/2019 | ID Prefix F0732<br>Reg. # 483.35(g)(1)-(4)<br>LSC | Correction<br>Completed<br>05/18/2019 | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |

| FOLLOWUP TO SURVEY COMPLETED ON<br>4/23/2019 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?   ☐ YES ☐ NO |
|---|---|