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

PRINTED: 12/07/2021 FORM APPROVED OMB NO. 0938-0391

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	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 VIRTUA HEALTH & REHAB MT HOLLY (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR THE PROVIDER OR SUPPLIER (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR THE PREFIX TAG FOR THE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCED TO THE APPROPRIATE DEFICIENCY FOR THE PREFIX RECHAPTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCED TO TH			315128	B. WING		08/26/2021	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

Electronically Signed

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.

09/07/2021