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

PRINTED: 11/15/2011 FORM APPROVED OMB NO. 0938-0391

Name of Promider or surpluer   Street Address, city, State, zip code   College Brive And South Alten Road   FLAT ROCK, NC 26731	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
INMIE OF PROVIDER OR SUPPLIER  HENDERSONVILLE HEALTH AND REHABILITATION  MAY ID SUMMARY STATEBENT OF DEPOSITORES (CITY, STATE, 2P CODE COLLEGE BRIVE AND SOUTH ALLEN ROAD FLAT ROCK, NC. 28731  PREPIX SUMMARY STATEBENT OF DEPOSITORES (EACH DEPOSITOR MUST BE PRECEDED BY FLIL. REGULATORY OR LSC IDEMINING INFORMATION)  FOR THE PROVIDER OR AND PROPERTY AND PRO				A. BUILDING			C		
HENDERSONVILLE HEALTH AND REHABILITATION  COLLEGE DRIVE AND SOUTH ALLEN ROAD FLAT ROCK, NO. 28731  (M4) ID PRETIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (ICACI DEFICIENCY MUST SEE PRECEDED BY PULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  No deficiencies were cited as a result of the complaint investigation Event ID # B6YD11  No deficiencies were cited as a result of the complaint investigation Event ID # B6YD11  The complaint investigation Event ID # B6YD11  COLLEGE DRIVE AND SOUTH ALLEN ROAD FLAT ROCK, NO. 28731  ID PRETIX TAG  PR			<b>345493</b> B. WING		NG_				
PREFIX TAG    CACH DEPICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION)   FIRST   TAG   CROSS-REFERENCED TO THE APPROPRIATE					COLLEGE DRIVE AND SOUTH ALLEN ROAD				
No deficiencies were cited as a result of the complaint investigation Event ID # B6YD11 .	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF		IOULD BE COMPLETION		
		INITIAL COMMENTS  No deficiencies were	e cited as a result of the			DEFICIENCY)			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	LABORATORY	DIDECTOR'S OF PROVIDERY	OLIDDI IED DEDDECENTATIVE OLOMATUDO			TITLE		(X6) DATE	

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.