PRINTED: 12/07/2020 FORM APPROVED

Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B WING	8. WING		C	
NH0444				11	11/16/2020		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
UNIVERSAL HEALTH CARE LILLINGTON 1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546							
(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 ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
D 000 Initial Comments		D 000					
	conducted on 11/10/2	nplaint investigation was 2020 - 11/16/2020 event ID # aces were cited, and nine of not substantiated.					
Division of Hea	Ith Service Regulation						
Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE						(X6) DATE	
Electronically Signed						12/07/20	
STATE FORM			6899	FSQP11	If cont	inuation sheet 1 of 1	