### Statement of Deficiencies and Plan of Correction

#### Name of Provider or Supplier
**HENDERSONVILLE HEALTH AND REHABILITATION**

#### Address
104 COLLEGE DRIVE
FLAT ROCK, NC  28731

#### Provider/Supplier/CLIA Identification Number
345493

#### Date Survey Completed
01/29/2015

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>There were no deficiencies cited as a result of the complaint investigation. Event ID# PH5011.</td>
<td></td>
</tr>
</tbody>
</table>

### Provider's Plan of Correction

- **ID**
- **PREFIX**
- **TAG**
- **Completion Date**

#### Laboratory Director's or Provider/Supplier Representative's Signature

Electronically Signed: 02/12/2015

---

*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.*