A. BUILDING _____________________________

B. WING _____________________________

DATE SURVEY COMPLETED
C 06/18/2015

LINCOLNTON REHABILITATION CENTER

1410 EAST GASTON STREET
LINCOLNTON, NC  28092

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>No deficiencies were cited as a result of the complaint investigation. Complaint intake #NC00107267.</td>
<td>F 000</td>
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</table>

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

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.