### Statement of Deficiencies and Plan of Correction

#### Name of Provider or Supplier

**Grace Heights Health & Rehab CTR**

#### Street Address, City, State, Zip Code

**109 Foothills Drive, Morganton, NC 28655**

#### Provider/Supplier/CLIA Identification Number

**345187**

#### Date Survey Completed

**07/30/2015**

### Initial Comments

The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey).

### Summary Statement of Deficiencies

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<th>ID Tag</th>
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<th>ID Tag</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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### 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.