**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID**

| (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 345523 |
| (X2) MULTIPLE CONSTRUCTION | |
| A. BUILDING _____________________________ | |
| B. WING _____________________________ | |

**DATE SURVEY COMPLETED**

| C | 02/09/2016 |

**NAME OF PROVIDER OR SUPPLIER**

UNIVERSAL HEALTH CARE/RAMSEUR

**STREET ADDRESS, CITY, STATE, ZIP CODE**

7166 JORDON ROAD
RAMSEUR, NC  27316

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**F 000 INITIAL COMMENTS**

No deficiency was cited as a result of the complaint survey dated 02/09/2016 NC00114059 Event ID. 39XX11.

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

Electronically Signed

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.

FORM CMS-2567(02-99) Previous Versions Obsolete
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