STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345159

(X2) MULTIPLE CONSTRUCTION
A. BUILDING __________________________
B. WING ____________________________

(X3) DATE SURVEY COMPLETED
C 03/22/2016

NAME OF PROVIDER OR SUPPLIER
LINCOLNTON REHABILITATION CENTER

345159

STREET ADDRESS, CITY, STATE, ZIP CODE
1410 EAST GASTON STREET
LINCOLNTON, NC  28092

ID PREFIX TAG
F 000 INITIAL COMMENTS F 000

No deficiencies were cited as a result of the complaint investigation event ID OIHF11 of 03/22/2016.

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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.