### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345355

### MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

### MULTIPLE CONSTRUCTION

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DATE SURVEY COMPLETED:** 06/30/2016

**MULTIPLE CONSTRUCTION**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
811 SNOWBIRD ROAD
ROBBINSVILLE, NC 28771

**NAME OF PROVIDER OR SUPPLIER**
GRAHAM HEALTHCARE AND REHABILITATION CENTER

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

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

**LATERAL DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

**TITLE**

**DATE** 07/01/2016

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.