**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**
345285

**(X3) DATE SURVEY COMPLETED:**
C 12/15/2016

**NAME OF PROVIDER OR SUPPLIER:**
MOUNTAIN HOME HEALTH AND REHAB

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
200 HERITAGE DRIVE
HENDERSONVILLE, NC  28739

**(X4) ID PREFIX TAG** | **SUMMARY STATEMENT OF DEFICIENCIES**
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F 000 | INITIAL COMMENTS

There were no deficiencies as a result of a complaint investigation done 12/15/16. Event ID #EK3511

**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.