### Statement of Deficiencies and Plan of Correction

#### Provider/Supplier/CLIA Identification Number:

34552

#### Date Survey Completed

04/24/2017

### Name of Provider or Supplier

The Shannon Gray Rehabilitation & Recovery Center

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

2005 Shannon Gray Court

Jamestown, NC  27282

### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F000</td>
<td></td>
<td></td>
<td>No deficiencies were cited as a result of the complaint investigation survey. Event ID# R2VG11</td>
</tr>
</tbody>
</table>

### Laboratory Director's or Provider/Supplier Representative's Signature

Electronically Signed

05/04/2017

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.