**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING ____________________________**

**B. WING _____________________________**

**NAME OF PROVIDER OR SUPPLIER**

BETHESDA HEALTH CARE FACILITY

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

3532 DUNN ROAD
EASTOVER, NC  28301

**ID**

PREFIX

TAG

**SUMMARY STATEMENT OF DEFICIENCIES**

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

**ID**

PREFIX

TAG

**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

**COMPLETION DATE**

**INITIAL COMMENTS**

There were no deficiencies cited as a result of the Complaint Investigation of 05/03/18, Event ID LR7P11.

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

Electronically Signed

05/08/2018

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.