### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

345534

**Date Survey Completed:**

05/09/2018

**Multiple Construction:**

B. Wing _____________________________

**Department of Health and Human Services**

Centers for Medicare & Medicaid Services

OMB NO. 0938-0391

**Name of Provider or Supplier:**

Sanford Health & Rehabilitation Co

**Street Address, City, State, ZIP Code:**

2702 Farrell Road
Sanford, NC 27330

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Description</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>A revisit and complaint investigation was conducted on 5/9/18. There were no deficiencies cited as a result of the survey. See Event KCEW11.</td>
<td></td>
</tr>
</tbody>
</table>

**Lab Director's or Provider/Supplier Representative's Signature:**

Electronically Signed

05/10/2018

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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.