A. BUILDING ____________________________  
B. WING ____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  
(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345329

(06/08/2018) PRINTED:  
FORM APPROVED OMB NO. 0938-0391

DATE SURVEY COMPLETED: 06/06/2018

R-C

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

GATEWAY REHABILITATION AND HEALTHCARE  
STREET ADDRESS, CITY, STATE, ZIP CODE: 2030 HARPER AVENUE NW, LENOIR, NC 28645

(x4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  
(x5) ID PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  
(x6) DATE

F 000 INITIAL COMMENTS

On June 6, 2018, The Division of Health Service Regulation, Nursing Home Licensure and Certification conducted a revisit. The facility was found to be in compliance effective May 10, 2018.

F 000

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
TITLE  
DATE

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.