**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 345159

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

C 02/14/2019

NAME OF PROVIDER OR SUPPLIER

LINCOLNTON REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1410 EAST GASTON STREET
LINCOLNTON, NC  28092

(X4) 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)

(X5) COMPLETION DATE

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<th>PROVIDER’S PLAN OF CORRECTION</th>
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<td><strong>INITIAL COMMENTS</strong></td>
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No deficiencies cited as result of survey event ID# SCON11.

LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE

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.
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On 02/14/19 the Division of Health Service Regulation Nursing Home Certification Section conducted an onsite follow up survey and complaint survey. The facility was found to be in compliance as of 01/31/19.

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