**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING ____________________________**

**NAME OF PROVIDER OR SUPPLIER**

**LUMBERTON HEALTH AND REHAB CENTER**

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

**1555 WILLIS AVENUE**

**LUMBERTON, NC  28358**

**DATE SURVEY COMPLETED**

**04/26/2019**

**R-C**

**ID**  
**PREFIX**  
**TAG**  

**F 000 INITIAL COMMENTS**

A desk review (Paper) Follow-up was completed on 04/26/19. The facility is back in compliance effective 04/19/19. Event ID # H3SM12.

**PROVIDER'S PLAN OF CORRECTION**

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

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

Electronically Signed

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.