A. BUILDING ______________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ______________________

B. WING _______________________

(X3) DATE SURVEY COMPLETED

R-C 03/05/2020

NAME OF PROVIDER OR SUPPLIER

SUMMERSTONE HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

485 VETERANS WAY KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG

(X5) COMPLETION DATE

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An onsite revisit was conducted on 3/3/20 through 3/5/20 and the facility is back in compliance effective 1/22/20.

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.