# Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345159

**Date Survey Completed:** 10/07/2020

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**Name of Provider or Supplier:** LINCOLNTON REHABILITATION CENTER

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

1410 EAST GASTON STREET
LINCOLNTON, NC  28092

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**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td>An on-site complaint investigation was conducted on 10/7/20. 9 of the 9 complaint allegations were not substantiated. Event ID# H4VC11</td>
</tr>
</tbody>
</table>

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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.

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Electronically Signed

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

**TITLE**

**DATE**

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Event ID: H4VC11
Facility ID: 923312