**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**STATEMENT OF DEFICIENCIES**

**A. BUILDING ____________________________**

**B. WING _____________________________**

**DATE SURVEY COMPLETED**

<table>
<thead>
<tr>
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<td>INITIAL COMMENTS</td>
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An unannounced COVID-19 follow-up survey was conducted on 11/18/20 through 11/23/20. The facility is back in compliance with F880 effective 10/30/20. See Event # MTVK12.

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

**TITLE**

**DATE**

Electronically Signed

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

PRINTED: 11/24/2020
FORM APPROVED
OMB NO. 0938-0391

**NAME OF PROVIDER OR SUPPLIER**

SANFORD HEALTH & REHABILITATION CO

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

2702 FARRELL ROAD
SANFORD, NC 27330

**F 000 INITIAL COMMENTS**

An unannounced COVID-19 follow-up survey was conducted on 11/18/20 through 11/23/20. The facility is back in compliance with F880 effective 10/30/20. See Event # MTVK12.

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