**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**COLLEGE PINES HEALTH AND REHABILITATION**

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

95 LOCUST STREET
CONNELLY SPRG, NC 28612

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<table>
<thead>
<tr>
<th>E 000</th>
<th>INITIAL COMMENTS</th>
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<tbody>
<tr>
<td>An unannounced on-site COVID-19 Focused Survey was conducted on 11/09/2020 through 11/10/20. Additional information was obtained on 11/12/20. Therefore, the exit date was changed to 11/12/20. The Facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart - B - Requirements for Long Term Care Facilities. Event ID # L2L111.</td>
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**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

**TITLE**

Electronically Signed

12/07/2020

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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.