**Statement of Deficiencies and Plan of Correction**

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

A. **Building:**

B. **Wing:**

**Date Survey Completed:** 01/27/2021

**Name of Provider or Supplier:**

**Universal Health Care/KING**

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

115 White Road
KING, NC 27021

**ID Prefix** | **Tag** | **Summary Statement of Deficiencies** | **ID Prefix** | **Tag** | **Provider's Plan of Correction** | **(X5) Completion Date**
---|---|---|---|---|---|---
E 000 | Initial Comments | E 000 | |
F 000 | **Initial Comments** | F 000 | |

An unannounced COVID-19 Focused Emergency Preparedness Survey was conducted on January 26-27, 2021. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# QKUD11

An unannounced COVID-19 Focused Infection Control Survey was conducted on January 26-27, 2021. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# QKUD11

**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.