### Statement of Deficiencies and Plan of Correction

**State of North Carolina**
**Department of Health and Human Services**
**Centers for Medicare & Medicaid Services**

**Provider/Supplier/CLIA Identification Number:** 345130

**Multiple Construction B. Wing:**

**Printed:** 04/26/2021

**Form Approved:** 03/26/2021

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**Provider's Plan of Correction**

Each corrective action should be cross-referenced to the appropriate deficiency.

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**Summary Statement of Deficiencies**

Each deficiency must be preceded by full regulatory or LSC identifying information.

#### F 000 INITIAL COMMENTS

An onsite complaint investigation survey was conducted from 3/25/21 through 3/26/21. Twenty-four of the twenty-four complaint allegations were not substantiated. Event ID# W6J411.

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**Laboratory Director's or Provider/Supplier Representative's Signature**

**Title**

Electronically Signed

04/06/2021

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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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**Event ID:** W6J411

**Facility ID:** 953050

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