A. BUILDING ________________________
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520

B. WING _____________________________

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED
C 05/14/2021

NAME OF PROVIDER OR SUPPLIER
PELICAN HEALTH THOMASVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
1028 BLAIR STREET
THOMASVILLE, NC 27360

(X4) ID PREFIX TAG

(X5) COMPLETION DATE

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>The survey team entered the facility on 5/12/2021 to conduct an unannounced complaint investigation. Additional information was obtained offsite on 5/13/2021 and 5/14/2021. Therefore, the exit date was 5/14/2021. 1 of the 1 complaint allegations were not substantiated. Event ID# UX1M11.</td>
</tr>
</tbody>
</table>

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

Electronically Signed
05/21/2021

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UX1M11 Facility ID: 20020005 If continuation sheet Page 1 of 1