## Statement of Deficiencies and Plan of Correction

**(X1) Provider/Supplier/CLIA Identification Number:**

345293

**(X2) Multiple Construction**

A. Building ________________________

B. Wing ________________________

**(X3) Date Survey Completed:**

R-C 08/17/2021

**RICHMOND PINES HEALTHCARE AND REHABILITATION CENTRE**

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

HIGHWAY 177 S BOX 1489
HAMILTON, NC 28345

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td>An onsite revisit was conducted on 8/15/21 through 8/17/21 and the facility is back into compliance effective 8/12/21. Event ID S61U12.</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td></td>
</tr>
</tbody>
</table>

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

Electronically Signed 08/20/2021

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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.