A. BUILDING ____________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345534

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ____________________________

B. WING ____________________________

(X3) DATE SURVEY COMPLETED

C 08/02/2021

NAME OF PROVIDER OR SUPPLIER

SANFORD HEALTH & REHABILITATION CO

STREET ADDRESS, CITY, STATE, ZIP CODE

2702 FARRELL ROAD
SANFORD, NC 27330

(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE

<table>
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>An unannounced complaint investigation was conducted on 7/27/21 through 8/02/21; Event MQQ811. Four of four allegations were not substantiated.</td>
<td>F 000</td>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

08/03/2021

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.