**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 345418

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING _____________________________

B. WING _____________________________

**(X3) DATE SURVEY COMPLETED**

C. 08/19/2021

**NAME OF PROVIDER OR SUPPLIER**

PELICAN HEALTH AT ASHEVILLE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1984 US HIGHWAY 70

SWANNANOA, NC 28778

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<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>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td>An onsite complaint investigation was conducted on 08/16/21 with exit from the facility 08/16/21. Additional information was obtained through 08/19/21. Therefore the exit date was changed to 08/19/21. 2 of the 2 allegations were unsubstantiated. Event ID #5YEH11.</td>
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</table>

**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.