## Statement of Deficiencies and Plan of Correction

**A. Building**  
**B. Wing**

**Provider/Supplier/CLIA Identification Number:** 345234

**Date Survey Completed:** 09/08/2021

**Provider or Supplier Name:** Lumberton Health and Rehab Center  
**Street Address:** 1555 Willis Avenue  
**City, State, Zip Code:** Lumberton, NC 28358

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td>A complaint investigation was completed on 09/08/21. Two of the 2 complaint allegations were unsubstantiated. Event ID # 7YEC11</td>
<td></td>
</tr>
</tbody>
</table>

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.

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

Electronically Signed

09/20/2021