**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1** PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345255

**X2** MULTIPLE CONSTRUCTION B. WING _____________________________

**X3** DATE SURVEY COMPLETED 09/21/2021

**NAME OF PROVIDER OR SUPPLIER**

CAROLINA CARE HEALTH AND REHABILITATION

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

111 HARRILSON STREET
CHERRYVILLE, NC 28021

**ID**

**PREFIX**

**TAG**

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An unannounced onsite complaint investigation survey was conducted on 09/21/21. Event ID# 783J11.

7 of the 7 complaint allegations were not substantiated.

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

Electronically Signed 10/04/2021

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.