STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING ____________________________
B. WING ____________________________

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345212
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

DATE SURVEY COMPLETED C 03/04/2022

NAME OF PROVIDER OR SUPPLIER

BETHESDA HEALTH CARE FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE

3532 DUNN ROAD EASTOVER, NC 28301

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

Electronically Signed 03/08/2022

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.