**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

A. BUILDING ______________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345213

(X2) MULTIPLE CONSTRUCTION B. WING ______________________

(X3) DATE SURVEY COMPLETED

R-C 03/31/2022

NAME OF PROVIDER OR SUPPLIER

UNIVERSAL HEALTH CARE LILLINGTON

STREET ADDRESS, CITY, STATE, ZIP CODE

1995 EAST CORNELIUS HARNETT BOULEVARD

LILLINGTON, NC  27546

(X4) ID PREFIX TAG (X5) COMPLETION DATE

<table>
<thead>
<tr>
<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>DATE</th>
</tr>
</thead>
</table>

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**INITIAL COMMENTS**

An onsite revisit was conducted on 3/30/2022 through 3/31/2022 and the facility is back in compliance effective 3/15/2022. The Directed Plan of Correction including the Root Cause Analysis was reviewed. Event ID. # KX2L12.

**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.