**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING _____________________________**

**B. WING _____________________________**

**DATE SURVEY COMPLETED**

C 03/16/2022

**NAME OF PROVIDER OR SUPPLIER**

HARNETT WOODS NURSING AND REHABILITATION CENTER

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

604 LUCAS ROAD
DUNN, NC  28334

**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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<td>F 000</td>
<td>INITIAL COMMENTS</td>
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An onsite complaint Investigation was conducted from 3/15/22 to 3/16/22. Event ID# 0EQ311. 2 of 5 complaint allegations were substantiated without deficiency. The following intake was investigated: NC00186622

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

Electronically Signed 03/23/2022

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.