**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

- **ID**
  - Prefix: "E"
  - Tag: 000
  - Initial Comments

- **ID**
  - Prefix: "F"
  - Tag: 000
  - Initial Comments

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**LEXINGTON HEALTH CARE CENTER**

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

17 CORNELIA DRIVE
LEXINGTON, NC  27292

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**NAME OF PROVIDER OR SUPPLIER**

LEXINGTON HEALTH CARE CENTER

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

- **ID**
  - Prefix: "E"
  - Tag: 000
  - Initial Comments
  - An on-site revisit and complaint investigation was conducted on 03/28/22 to 03/29/22 and the facility is back into compliance effective 02/14/2022.

- **ID**
  - Prefix: "F"
  - Tag: 000
  - Initial Comments
  - An onsite revisit and complaint survey was conducted on 3/28/2022 to 3/29/2022 and the facility is back into compliance effective 2/14/2022.

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**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.