PRINTED: 11/07/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND LAN OF CONNECTION		IDENTIFICATION NOWIDEN.	A. BUILDING:			
		NH0480	B. WING		09/0	7/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
THE LAURELS OF HENDERSONVILLE 290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE	
L 000	L 000 INITIAL COMMENTS		L 000			
	An unannounced com conducted 9/6/2022 ti were 4 allegations in unsubstantiated. The	nplaint investigation was hrough 9/7/2022. There vestigated and all were following intakes were 30, NC00192140, and				
	alth Service Pegulation			1		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

09/29/22

Electronically Signed