PRINTED: 12/16/2024 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A. BOILDING.		С
		NH0509	B. WING		12/03/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
WILKESBORO HEALTH AND REHABILITATION  204 OLD BRICKYARD ROAD  NORTH WILKESBORO, NC 28659					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
L 000 INITIAL COMMENTS		L 000			
	An unannounced con conducted on 12/03/2 investigated NC0022	applaint investigation was 24 with the following intake 4422. One (1) of the 1 ult in a deficiency. Event ID			

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

(X6) DATE TITLE

**Electronically Signed** 

STATE FORM 6899 CUXP11 If continuation sheet 1 of 1