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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>          |                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>345386</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                             |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>07/22/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>WILKES REGIONAL MEDICAL CTR SN</b> |                                                                                                                                                                                                                                                             |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1370 WEST D STREET , NORTH WILKESBORO, North Carolina,<br/>28659</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                |                                                                        |  | ID<br>PREFIX<br>TAG                                                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| F0000                                                                 | <b>INITIAL COMMENTS</b><br><br>A paper follow-up was conducted on 07/18/25 through 07/22/25 and the facility is back into compliance effective 05/22/25. The Directed Plan of Correction including the Root Cause Analysis was reviewed. Event ID: UH8N-H2. |                                                                        |  | F0000                                                                                                            |                                                                                                                          |                                                 |                            |

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 reverse for further 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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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