

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0472	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/22/2018
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NAME OF PROVIDER OR SUPPLIER HIGHLAND ACRES NURSING AND REHABILITATION (STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	<p>INITIAL COMMENTS</p> <p>There were no deficiencies cited as a result of this complaint investigation survey of 03/22/18. Event ID# DTVE11.</p>	L 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE 	(X6) DATE 03/27/18
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