## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345247  
**Multiple Construction:**
- A. Building ____________________________  
- B. Wing ____________________________

### Name of Provider or Supplier

**Valley Nursing Center**

### Street Address, City, State, Zip Code

581 NC HWY 16 SOUTH  
Taylorsville, NC 28681

### Summary Statement of Deficiencies

**Summary Statement of Deficiencies**

**ID# 58CQ11.**

- No deficiencies cited as result of survey event ID# 58CQ11.

### Provider's Plan of Correction

**Provider's Plan of Correction**

- **ID Prefix**
  - F 000
  
  **Initial Comments**
  
  No deficiencies cited as result of survey event ID# 58CQ11.

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**Laboratory Director's or Provider/Supplier Representative's Signature**

**Title**

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**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.**