### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**
345400

**Multiple Construction:**

**A. Building:**

**B. Wing:**

**Date Survey Completed:**
10/31/2013

**Name of Provider or Supplier:**
Skyland Care Center

**Address:**
193 Asheville Hwy
Sylva, NC 28779

**Provider's Plan of Correction:**

Each corrective action should be cross-referenced to the appropriate deficiency.

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<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
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<th>Provider's Plan of Correction</th>
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<td>INITIAL COMMENTS</td>
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The facility is in compliance with the requirements of 42 CFR Part 283, Subpart B for Long Term Care Facilities (General Health Survey).

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

Electronically Signed

**Date:**
11/15/2013

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.