STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345448

(X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:
   A. BUILDING __________________________
   B. WING ___________________________

(X3) DATE SURVEY COMPLETED:
   C 09/18/2015

NAME OF PROVIDER OR SUPPLIER: MAPLE GROVE HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 308 WEST MEADOWVIEW ROAD, GREENSBORO, NC 27406

(X4) ID PREFIX TAG: SUMMARY STATEMENT OF DEFICIENCIES
   (EACH DEFICIENCY MUST BE PRECEDED BY Full REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F000</td>
<td>CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY</td>
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F000 INITIAL COMMENTS

No deficiencies were cited as a result for the complaint investigation Event ID #XYNL11.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

(TITLE) DATE: 09/30/2015

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.