A. BUILDING ________________  
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345341  
(B. WING ________________)

(X3) DATE SURVEY COMPLETED  04/27/2017

NAME OF PROVIDER OR SUPPLIER  SILVER BLUFF INC  
STREET ADDRESS, CITY, STATE, ZIP CODE  100 SILVER BLUFF DRIVE  CANTON, NC  28716

(X4) ID PREFIX TAG  SUMMAR Y 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) COMPLETION DATE

F 000  INITIAL COMMENTS

The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care facilities (General Health Survey).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
ELECTRONICALLY SIGNED  05/01/2017

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.

FORM CMS-2567(02-99) Previous Versions Obsolete  
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Facility ID: 923454  
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