**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING ____________________________**

**B. WING _____________________________**

**NAME OF PROVIDER OR SUPPLIER**

YADKIN NURSING CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

903 W MAIN STREET
YADKINVILLE, NC  27055

**DATE SURVEY COMPLETED**

01/16/2018

**PROVIDER’S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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<td>INITIAL COMMENTS</td>
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No deficiencies were cited as a result of this compliant investigation. Event ID MMQR11

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.

Electronically Signed

01/18/2018

LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE

TITLe

(X6) DATE 01/18/2018