### Statement of Deficiencies and Plan of Correction

#### A. Building ______________________

**Provider/Supplier/CLIA Identification Number:** 345050

**Date Survey Completed:** 04/09/2018

#### B. Wing _____________________________

**Statement of Deficiencies and Plan of Correction**

#### Name of Provider or Supplier

**Jacob's Creek Nursing and Rehabilitation Center**

**Street Address, City, State, Zip Code:**

1721 Bald Hill Loop

Madison, NC 27025

#### Summary Statement of Deficiencies

- **ID**: {F 000}
- **Prefix**: INITIAL COMMENTS
- **Tag**: The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey) of 4/9/18, Event ID # 4TWV12.

### Provider's Plan of Correction

- **ID**: {F 000}
- **Prefix**: PROVIDER'S PLAN OF CORRECTION
- **Tag**: (Each corrective action should be cross-referenced to the appropriate deficiency)

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

**Electronically Signed**

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.