### Statement of Deficiencies and Plan of Correction

**A. Building**

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

**B. Wing**

**Date Survey Completed:** 10/23/2018

**State of Provider or Supplier:** Jacob's Creek Nursing and Rehabilitation Center

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

1721 Bald Hill Loop
Madison, NC 27025

**Department of Health and Human Services**

**Centers for Medicare & Medicaid Services**

**OMB NO. 0938-0391**

**Printed:** 12/05/2018

**Form Approved:**

**Summary Statement of Deficiencies**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Initial Comments</th>
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<tbody>
<tr>
<td>F000</td>
<td>INITIAL COMMENTS</td>
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No deficiencies were cited as a result of the complaint investigation survey on 10/23/18. Event ID# CSY711.

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

**Title:**

**Date:** 10/24/2018

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.