**Statement of Deficiencies and Plan of Correction**

**Name of Provider or Supplier**: Macon Valley Nursing and Rehabilitation Center  
**Street Address, City, State, Zip Code**: 3195 Old Murphy Road, Franklin, NC 28734

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td></td>
<td>An onsite revisit was conducted on 07/31/19 and the facility is back into compliance effective 07/03/19.</td>
<td>F 000</td>
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**Laboratory Director's or Provider/Supplier Representative's Signature**

**Title**

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.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
R-C 07/31/2019

NAME OF PROVIDER OR SUPPLIER

MACON VALLEY NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
3195 OLD MURPHY ROAD FRANKLIN, NC 28734

(X4) ID PREFIX TAG
(X5) COMPLETION DATE

<table>
<thead>
<tr>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 000 INITIAL COMMENTS</td>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

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