## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### NAME OF PROVIDER OR SUPPLIER

**SILVER BLUFF INC**

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

100 SILVER BLUFF DRIVE
CANTON, NC  28716

### SUMMARY STATEMENT OF DEFICIENCIES

**ID** | **PREFIX** | **TAG** | **DESCRIPTION**
---|---|---|---
F 000 | INITIAL COMMENTS

A complaint investigation survey was conducted on 10/01/19. There were a total of three allegations investigated. Two of the three allegations were unsubstantiated and one of the three was substantiated but not cited.

**Event ID:** YYMC11

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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.