A. BUILDING ______________________

B. WING _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
MARYFIELD NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
1315 GREENSBORO ROAD HIGH POINT, NC 27260

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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An unannounced complaint investigation was conducted 11/12/20 through 11/13/20. 1 of 1 complaint allegation was unsubstantiated. Event ID: 5CXU11

LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE
Electronically Signed
11/18/2020

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.