| CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938- STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345102 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE T11/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE T5 FISHER LOOP MAGGIE VALLEY NURSING AND REHABILITATION MAGGIE VALLEY, NC 28751 (X4) ID (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION MUST BE PRECEDED BY FULL (xet COMPLIER) | DEPARTI | MENT OF HEALTH AN | ID HUMAN SERVICES | | | | | RM APPROVED | |
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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C A. BUILDING | CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | | | |
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| | | | SUPPLIER REPRESENTATIVE'S SIGNATU | RE | | TITLE | | (X6) DATE 11/30/2023 | |

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.

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