## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2011 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
345110		B. WIN	B. WING			C <b>04/13/2011</b>	
NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 360 BALSM ROAD WAYNESVILLE, NC 28786				
SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORRECTIVE ACTION SHOUL	CTION SHOULD BE COMP O THE APPROPRIATE		
0 INITIAL COMMENTS		F	000				
No deficiencies were Event ID FX6J11.	cited as a result of CI.						
DIDECTORIS OF PROVIDER	CLIDDLIED DEDDESENTATIVE'S SIGNATUR	DE		TITI F		(X6) DATE	
	SUMMARY ST. (EACH DEFICIENC' REGULATORY OR I  INITIAL COMMENTS  No deficiencies were Event ID FX6J11.	CORRECTION  IDENTIFICATION NUMBER:  345110  COVIDER OR SUPPLIER  CARE OF WAYNESVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  No deficiencies were cited as a result of CI. Event ID FX6J11.	A. BUIL  345110  345110  COVIDER OR SUPPLIER  CARE OF WAYNESVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  F  No deficiencies were cited as a result of CI.	TOVIDER OR SUPPLIER  CARE OF WAYNESVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  No deficiencies were cited as a result of CI. Event ID FX6J11.	CORRECTION  DENTIFICATION NUMBER: 3.45110  STREET ADDRESS, CITY, STATE, ZIP CODE 360 BALSIN ROAD WAYNESVILLE, C 28786  SUMMARY STATEMENT OF DEPICIENCIES  (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSS IDENTIFYING INFORMATION)  INITIAL COMMENTS  No deficiencies were cited as a result of CI. Event ID FX6J11.	CORRECTION    IDENTIFICATION NUMBER:   A BUILDING   DA/1   345110   B. WING   D4/1   O4/1   O	

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.