CENTERS FOR MEDICARE & MEDICAID SERVICES   OMB NO. 0     STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   (X2) MULTIPLE CONSTRUCTION A. BUILDING   (X3) DATE SL COMPLE C     NAME OF PROVIDER OR SUPPLIER   345129   B. WING   C     AUTUMN CARE OF MOCKSVILLE   STREET ADDRESS, CITY, STATE, ZIP CODE   1007 HOWARD STREET MOCKSVILLE, NC 27028   1007 HOWARD STREET MOCKSVILLE, NC 27028     (X4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG     F 000   INITIAL COMMENTS   F 000   F 000   F 000	
AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING   COMPLE     345129   B. WING   08/08     NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   08/08     AUTUMN CARE OF MOCKSVILLE   1007 HOWARD STREET   MOCKSVILLE, NC 27028     (X4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   ID PREFIX TAG     F 000   INITIAL COMMENTS   F 000   F 000	(X5) COMPLETION
345129 B. WING 08/08   NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1007 HOWARD STREET   AUTUMN CARE OF MOCKSVILLE 1007 HOWARD STREET MOCKSVILLE, NC 27028   (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) INITIAL COMMENTS   F 000 INITIAL COMMENTS F 000	(X5) COMPLETION
NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE     AUTUMN CARE OF MOCKSVILLE   1007 HOWARD STREET     MOCKSVILLE, NC 27028   MOCKSVILLE, NC 27028     (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES     PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL     TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL     REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG     CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DEFICIENCY)     F 000   INITIAL COMMENTS     There were no deficiencies cited as a result of   F 000	(X5) COMPLETION
AUTUMN CARE OF MOCKSVILLE   MOCKSVILLE, NC 27028     (X4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     F 000   INITIAL COMMENTS   F 000     There were no deficiencies cited as a result of   F 000	COMPLETION
MOCKSVILLE, NC 27028     (X4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     F 000   INITIAL COMMENTS   F 000     There were no deficiencies cited as a result of   F 000	COMPLETION
PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     F 000   INITIAL COMMENTS   F 000     There were no deficiencies cited as a result of   F 000	COMPLETION
There were no deficiencies cited as a result of	
the Complaint Investigation. Event DE9B11.	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6 Electronically Signed 08	6) DATE

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.

PRINTED: 08/16/2018