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

PRINTED: 10/18/2018 FORM APPROVED OMB NO. 0938-0391

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3)	DATE SURVEY COMPLETED	
	345351	B. WING			R-C <b>10/04/2018</b>	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>l</u>	10/04/2016	
AUTUMN CARE OF SALUDA			SALUDA, NC 28773			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
INITIAL COMMENTS  No deficiencies were cited as a result of the		F 0	00			
	CORRECTION  COVIDER OR SUPPLIER  CARE OF SALUDA  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR L  INITIAL COMMENTS  No deficiencies were	CORRECTION IDENTIFICATION NUMBER:  345351  COVIDER OR SUPPLIER  CARE OF SALUDA  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	A. BUILDIN  345351  B. WING  COVIDER OR SUPPLIER  CARE OF SALUDA  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  F 0  No deficiencies were cited as a result of the	A. BUILDING  345351  B. WING  COVIDER OR SUPPLIER  CARE OF SALUDA  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION INFORMATION)  F 000  No deficiencies were cited as a result of the	A. BUILDING	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) 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.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
					R-C
		345351	B. WING		10/04/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
A LITLIMAL A	CARE OF SALUDA			501 ESSEOLA CIRCLE	
AUTUMN	CARE OF SALUDA		;	SALUDA, NC 28773	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA	
		,		DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
	Service Regulation, N Certification conducte	The Division of Health lursing Home Licensure and a revisit. The facility was ance effective 10/04/18.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION IG	(X3)	DATE SURVEY COMPLETED
		345351	B. WING _			R <b>10/04/2018</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/04/2010
AUTUMN	CARE OF SALUDA			501 ESSEOLA CIRCLE		
0	CUMMADVCT	ATEMENT OF DEFICIENCIES		SALUDA, NC 28773	DECTION	(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 000	INITIAL COMMENTS		F 0	00		
	Service Regulation, N Certification conducted	The Division of Health Jursing Home Licensure and ed a revisit. The facility was ance effective 10/04/18.				

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