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

PRINTED: 12/21/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345511	B. WING		C <b>12/06/2018</b>
NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF STATESVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 VANHAVEN DRIVE STATESVILLE, NC 28625	12/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 000		
		cited as a result of the n. Event ID # 513E11.			
ARODATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUI	RE	TITLE	(X6) DATE

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

**Electronically Signed** 12/21/2018

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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	(X3	) DATE SURVEY COMPLETED
		345511	B. WING _			R-C <b>12/06/2018</b>
NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF STATESVILLE				STREET ADDRESS, CITY, STATE, ZIP ( 2001 VANHAVEN DRIVE STATESVILLE, NC 28625	CODE	12/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 000	Regulation, Nursing	vision of Health Service Home Licensure and	F 0	000		
		ed a revisit. The facility was lance effective 11/12/18.				
ABORATORY	DIRECTOR'S OF PROVINCE	/SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE

Electronically Signed

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		NH0599	B. WING		R-C			
NAME OF P	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE							
	AUTUMN CARE OF STATESVILLE  2001 VANHAVEN DRIVE  AUTUMN CARE OF STATESVILLE							
AOTOMIN	OARE OF GTATEOVICEE	STATESVIL	LE, NC 28625			_		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	:		
L 000	INITIAL COMMENTS		L 000					
L 000	On 12/06/18, the Divi- Regulation, Nursing F Certification conducte	sion of Health Service	L 000					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 

TITLE (X6) DATE 12/21/18

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