**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 345268

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
AUTUMN CARE OF MARSHVILLE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
311 W PHIFER ST
MARSHVILLE, NC 28103

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

**DATE SURVEY COMPLETED**
02/02/2012

**MULTIPLE CONSTRUCTION B. WING _____________________________**

**ID PREFIX TAG**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 000 | INITIAL COMMENTS | If a 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.

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.

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

**TITLE**

**DATE**

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**If continuation sheet Page 1 of 1**

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**Event ID: DYTH11**

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**Facility ID: 922952**

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**PRINTED: 02/06/2012**

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**FORM APPROVED**

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