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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  
|--------------------|-----------------------------------|  
| F 000              | INITIAL COMMENTS  
No deficiencies were cited as of complaint investigation survey of 1/12/16. Event ID#5RQ211 for intake #NC00113378.  

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
Electronically Signed  
01/15/2016

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.