**NAME OF PROVIDER OR SUPPLIER**

AUTUMN CARE OF CORNELIUS

**STREET ADDRESS, CITY, STATE, ZIP CODE**

19530 MOUNT ZION PARKWAY

CORNELIUS, NC  28031

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>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>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS F 000</td>
<td></td>
<td>There were no deficiencies cited as a result of this complaint investigation. Event ID ZI3T11.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

Electronically Signed

03/20/2017

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.