### Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER**

**AVANTE AT THOMASVILLE**

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

1028 BLAIR STREET

THOMASVILLE, NC  27360

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**SUMMARY STATEMENT OF DEFICIENCIES**

**ID**

**PREFIX**

**TAG**

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<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td></td>
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</tbody>
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During the complaint investigation survey Event ID #U61O11, there were no citations for the allegations investigated for intakes: NC00130098; NC00129927; and NC00129517.

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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.