### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Autumn Care of Waynesville  
**Street Address, City, State, Zip Code:** 360 Old Balsam Road, Waynesville, NC 28786  
**Form Approved:** 04/27/2018

#### Summary Statement of Deficiencies

**Deficiency:** An offsite paper follow up was completed 04/47/18. Monitoring tools and inservice sign in sheets and content was reviewed. The facility was found in compliance with F641 effective 04/17/18.

**Provider's Plan of Correction**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
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**Laboratory Director's or Provider/Supplier Representative's Signature**

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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**Electronic Signature**

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