STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING ________________________

B. WING _____________________________

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268

DATE SURVEY COMPLETED: 07/24/2018

NAME OF PROVIDER OR SUPPLIER

AUTUMN CARE OF MARSHVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE

311 W PHIFER STREET
MARSHVILLE, NC  28103

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

ID  PREFIX  TAG

F 000  INITIAL COMMENTS  F 000

An unannounced, on-site investigation was completed 7/24/18 and no deficiency was sited regarding intake NC00141138.

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

Electronically Signed 08/08/2018

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.