A. BUILDING _____________________________

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345567

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED
11/06/2020

NAME OF PROVIDER OR SUPPLIER

AUTUMN CARE OF CORNELIUS

STREET ADDRESS, CITY, STATE, ZIP CODE

19530 MOUNT ZION PARKWAY
CORNELIUS, NC 28031

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(X5) ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td>An unannounced on-site COVID-19 Focused Survey was conducted on 11/02/20 through 11/03/20 with exit from the facility on 11/03/20. Additional information was obtained through 11/06/20. Therefore, the exit date was changed to 11/06/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID: 3KMX11.</td>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>An unannounced on-site COVID-19 Focused Survey and complaint investigation was conducted on 11/02/20 through 11/03/20 with exit from the facility on 11/03/20. Additional information was obtained through 11/06/20. Therefore, the exit date was changed to 11/06/20. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Center for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. There were 34 allegations investigated and they were all unsubstantiated. Event ID# 3KMX11.</td>
<td></td>
</tr>
</tbody>
</table>

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

Electronically Signed

DATE
11/17/2020

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.