A. BUILDING ________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345511

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
11/25/2020

(X4) ID PREFIX TAG
E 000 Initial Comments
F 000 INITIAL COMMENTS

(X5) COMPLETION DATE
E 000
F 000

NAME OF PROVIDER OR SUPPLIER
AUTUMN CARE OF STATESVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
2001 VANHAVEN DRIVE
STATESVILLE, NC  28625

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

E 000 Initial Comments
An unannounced COVID-19 Focused Survey was conducted on 11/25/2020. 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: 61PC11.

F 000 INITIAL COMMENTS
An unannounced COVID-19 Focused Infection Control and Compliant Survey was conducted on 11/25/2020. 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. 1 of 1 complaint allegation was unsubstantiated. Event ID# 61PC11.

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

Electronically Signed
12/09/2020

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.