STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING _____________________________
B. WING _____________________________

DATE SURVEY COMPLETED
05/04/2021

MULTIPLE CONSTRUCTION

NAME OF PROVIDER OR SUPPLIER
AUTUMN CARE OF BISCOE

STREET ADDRESS, CITY, STATE, ZIP CODE
401 LAMBERT ROAD
BISCOE, NC 27209

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

F 000 INITIAL COMMENTS

An unannounced complaint investigation was conducted on site 5/3/2021 and continued remotely until 5/4/2021. Event ID# VK6V11.

1 of the 2 facility reported incidents was substantiated but did not result in a deficiency.

1 of the 2 facility reported incidents was unsubstantiated.

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

Electronically Signed
05/13/2021

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.