DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345000	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **01/20/2021**

NAME OF PROVIDER OR SUPPLIER **AUTUMN CARE OF BISCOE**	STREET ADDRESS, CITY, STATE, ZIP CODE **401 LAMBERT ROAD** **BISCOE, NC 27209**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on site 1/19/21 and continued remotely until 1/20/21. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b) (6), Subpart-B-Requirements for Long Term Care Facilities. Event ID #4URG11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted on site 1/19/21 and continued remotely until 1/20/21. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		