

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0595	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/01/2023
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NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MYRTLE GROVE	STREET ADDRESS, CITY, STATE, ZIP CODE 5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412
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(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) COMPLETE DATE
D 000	<p>Initial Comments</p> <p>A complaint investigation was conducted on site from 11/28/23 through 11/30/23 and finished remotely on 12/02/23. Event ID#P02U11</p> <p>The following intake was investigated: NC00203214</p> <p>1 of 1 complaint allegation did not result in deficiency.</p>	D 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 12/18/23
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