| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495253 | A. BUILDING _____ B. WING _____ | R-C 08/05/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF NORFOLK | 1401 HALSTEAD AVENUE REVISED NORFOLK, VA 23502 |

| (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 |
|---|---|---|---|---|
| {F 000} | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid revisit to an abbreviated survey conducted 5/25/21 through 5/27/21, was conducted 08/03/21 through 08/04/21. The facility was in compliance with 42 CFR Part 483 the Federal Long-Term Care regulations. No complaints were investigated during the survey.<br><br>The census in this 120 certified bed facility was 93 at the time of the survey. The survey sample consisted of 5 current Resident reviews (Residents 101 through 105). | {F 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Abernathy, LNHA | TITLE: Administrator | (X6) DATE: 8/18/2021

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...llowing 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.