

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011376	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2025
NAME OF PROVIDER OR SUPPLIER AUTUMN VIEW ASSISTED LIVING # 3		STREET ADDRESS, CITY, STATE, ZIP CODE 232 COUNTRY TIME CIRCLE LEICESTER, NC 28748		
(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
{C 000}	Initial Comments Report by Jonathan Gamsey Based on your acceptable Plan of Corrections received on April 04 , 2025 for a Biennial Construction Survey, all previously cited deficiencies are noted as being corrected. Therefore no further action is required.	{C 000}		

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

TITLE

(X6) DATE