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

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - DARTMOUTH (A4.ID PROVIDER OR SUPPLIER (A4.ID PROVIDER OR SUPPLIER COLOR OF PROVIDER OR SUPPLIER	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - DARTMOUTH PREVIOUS SEASON OF SUPPLIER (CAY) ID PREVIOUS SEASON OR SUPPLIER SEASON OF SUPPLIE				A. BUILDING			С		
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PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS No deficiencies cited as result of survey event ID# I21Q11.						300 PROVIDENCE RD			
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LARODATORY DIRECTOR'S OR PROVIDER/SLIPPLIER REPRESENTATIVE'S SIGNATURE TITLE (YE) DATE		INITIAL COMMENTS No deficiencies cited				DEFICIENCY)			
	LABORATORY	DIDECTOR'S OR PROVIDERY	QUIDDI IED DEDDECENTATIVE COMATUDE			TITLE		(Y6) DATE	

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.