PRINTED: 04/06/2015 FORM APPROVED

Division of Health Service Regulation

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2300 ABERDEEN BOULEVARD GASTONIA, NC 28095 (P44) ID PREFIX TAG (P45) ID PREFIX TAG (| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE S COMPL | (X3) DATE SURVEY COMPLETED | |
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| COURTLAND TERRACE 2300 ABERDEEN BOULEVARD GASTONIA, NC 28054 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) L 000 INITIAL COMMENTS No deficiencies cited as result of survey event L 000 ABERDEEN BOULEVARD GASTONIA, NC 28054 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) No deficiencies cited as result of survey event | | | NH0494 | B. WING | | 03/2 | 27/2015 | |
| COURTLAND TERRACE GASTONIA, NC 28054 (X4) ID PREFIX TAG L 000 INITIAL COMMENTS No deficiencies cited as result of survey event CASTONIA, NC 28054 ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE L 000 No deficiencies cited as result of survey event | | | | | | | | |
| (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) L 000 INITIAL COMMENTS No deficiencies cited as result of survey event | I COURTLAND TERRACE | | | | | | | |
| No deficiencies cited as result of survey event | PREFIX | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETE | |
| | L 000 | L 000 INITIAL COMMENTS | | L 000 | | | | |
| | | No deficiencies cited | | | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE