DEPARTMENT OF HEALTH AND HUMAN SERVICES					FORM APPROVED	
S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-0391	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
	345457			C 01/12/2017		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HEAI TH CARE CENTER			2065 LYON STREET			
			GASTONIA, NC 28052			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COM		(X5) COMPLETION DATE	
INITIAL COMMENTS		F 0	00			
No deficiencies were cited as a result of the complaint investigation. Event ID# XPXB11.						
					(X6) DATE	
	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER HEALTH CARE CENTER SUMMARY ST (EACH DEFICIENC REGULATORY OR I INITIAL COMMENTS No deficiencies were complaint investigatio	ES FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345457 ROVIDER OR SUPPLIER HEALTH CARE CENTER ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# XPXB11.	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A. BUILDIN 345457 B. WING ROVIDER OR SUPPLIER B. WING HEALTH CARE CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID INITIAL COMMENTS F 0 No deficiencies were cited as a result of the F 0	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (x1) PROVIDER/SUPPLIER_LIAL (x2) MULTIPLE CONSTRUCTION ABUIDING	MENT OF HEALTH AND HUMAN SERVICES FOR MEDICALS SOME NOR SUPPLEX ONE NUMBER OF DEFICIENCES OF DE	

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.

PRINTED: 01/27/2017