REVIEWED BY REVIEWE			DATE		TITLE				DATE	
REVIEWED BY STATE AGENCY (INITIALS)			DATE		SIGNATURE C	OF SURVEYOR			DATE	
		_	LSC				LSC			
Reg. # Completed LSC			Reg. #	Reg. #		Completed	pleted Reg. #			Completed
		Correction	ID Prefix			Correction	ID Prefix			Correction
		_	LSC				LSC			
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		Correction	ID Prefix			Correction	ID Prefix			Correction
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		Correction	ID Prefix			Correction	ID Prefix			Correction
		08/06/2021	LSC			08/06/2021	LSC			
483.21(b)(1)		Completed	Reg. #	483.21(1	)(2)(i)-(iii)	Completed	Reg.#			Completed
F0656		Correction	ID Prefix	F0657		Correction	ID Prefix			Correction
		08/06/2021	LSC			08/06/2021	LSC			08/06/2021
483.10(j)(1)-(4)		Completed	Reg. #	483.20(	1)	Completed	Reg.#	483.21(a)(1)-(3)		Completed
F0585		Correction	ID Prefix	F0641		Correction	ID Prefix	F0655		Correction
		Y5	Y4			Y5	Y4			Y5
y report form).		DATE	ITEM			DATE	ITEM			DATE
to show those of and the date so	deficiencie uch correc	es previously repo ctive action was a	orted on the accomplished	CMS-25 d. Each	67, Statement deficiency sho	t of Deficiencies and buld be fully identified	Plan of Cor d using eithe	rection, that have ler the regulation or	LSC	
GASTONIA, NC 28054										
								CODE		
ATION NUMBER	Y1	A. Building B. Wing						Y2	8/27/20	21 <sub>Y3</sub>
R / SUPPLIER / C	CLIA /	T		IFIC	ATION I	REVISIT RE	PORT		DATE O	F REVISIT
	FACILITY AND TERRACE It is completed to show those of and the date sinumber and the property of the second	FACILITY AND TERRACE  It is completed by a qualito show those deficiencies and the date such correct number and the identificaty report form).  F0585  483.10(j)(1)-(4)  F0656  483.21(b)(1)  BY ENCY  REVIEW (INITIAL	ATION NUMBER / CLIA / ATION NUMBER / Y1	ATION NUMBER Y1 AND TERRACE  This completed by a qualified State surveyor for the Meto show those deficiencies previously reported on the and the date such corrective action was accomplished number and the identification prefix code previously sly report form).  The part of the method of the identification prefix code previously sly report form.  The part of the method of the identification prefix code previously sly report form.  The part of the method of the identification prefix code previously sly report form.  The part of the method of the identification prefix code previously sly report form.  The part of the method of the identification prefix code previously sly report form.  The part of the method	ATION NUMBER ATION NUMBER ATION NUMBER AND TERRACE  To scompleted by a qualified State surveyor for the Medicare, I to show those deficiencies previously reported on the CMS-25 and the date such corrective action was accomplished. Each number and the identification prefix code previously shown on 7 report form).  To DATE TIEM Y5 AND TERRACE  TIEM Y5 AND TERRACE  TIEM Y6 AND TERRACE  TO T	ATION NUMBER / LIA / ATION NUMBER / LIA SUID PRETIX / LIA SUID PRE	ATION NUMBER / A Building B. Wing  FACILITY AND TERRACE  STREET ADDRESS, CITY 2300 ABERDEEN BOULE GASTONIA, NC 28054  Tt is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laborator to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and the date such corrective action was accomplished. Each deficiency should be fully identified number and the identification prefix code previously shown on the CMS-2567 (prefix codes show / report form).  The part of the part of the medicare of the CMS-2567 (prefix codes show / report form).  The part of the part of the part of the CMS-2567 (prefix codes show / report form).  The part of the part of the part of the completed of the CMS-2567 (prefix codes show / report form).  The part of the part of the completed of the complete of the c	A Building B. Wing  FACILITY NND TERRACE  STREET ADDRESS, CITY, STATE, ZIF 2800 ABERDEEN BOULEWARD GASTONIA, NC 28054  T is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvem to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Cor and the date such corrective action was accomplished. Each deficiency should be fully identified using either number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left yr port form).	ATION NUMBER   ADJUNCTION   A	DATE OF PLEER CLIA! ACTION NUMBER   Multiple CONSTRUCTION   A Building   Completed   Compl

7/9/2021

FOLLOWUP TO SURVEY COMPLETED ON

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO