

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0121	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2023
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NAME OF PROVIDER OR SUPPLIER SHARON TOWERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 SHARON ROAD CHARLOTTE, NC 28210
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(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
L 000	<p>INITIAL COMMENTS</p> <p>A complaint investigation was conducted 9/25/23 through 9/28/23. Event ID# K2E311. The following State Licensure intake was investigated NC00203474. 5 of 5 allegations did not result in a deficiency.</p>	L 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE
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