STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345331

(2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________
B. WING _____________________________

(3) DATE SURVEY COMPLETED

C 04/04/2011

NAME OF PROVIDER OR SUPPLIER

SARDIS OAKS

STREET ADDRESS, CITY, STATE, ZIP CODE

5151 SARDIS RD
CHARLOTTE, NC  28270

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)

F 000 INITIAL COMMENTS

No deficiencies were cited as a result of the complaint investigation of 4/4/11. Event ID #2YVT11.

F 000

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X4) DATE

(X5) COMPLETION 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2YVT11

Facility ID: 923444

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