**Name of Provider or Supplier**

**GOLDEN LIVINGCENTER - STARMOUNT**

**Street Address, City, State, Zip Code**

109 S HOLDEN ROAD
GREENSBORO, NC 27407

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**Deficiency Table**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td>No deficiencies were cited as a result of this complaint investigation Event # G8Ki11.</td>
<td>F 000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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.

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**Laboratory Director's or Provider/Supplier Representative's Signature**

**Title**

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**Form CMS-2587(02-09) Previous Versions Obsolete**

Event ID: G8Ki11  Facility ID: 063473

If continuation sheet Page 1 of 1