A. BUILDING ________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345388

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ___________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED
C 03/08/2013

NAME OF PROVIDER OR SUPPLIER

HUNTER WOODS NURSING AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE
620 TOM HUNTER RD
CHARLOTTE, NC  28256

(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) COMPLETION DATE

F 000 INITIAL COMMENTS

No deficiencies cited as a result of survey event ID# YC2L11.

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

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.