**STATION OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201

A. BUILDING _____________________________

B. WING _____________________________

(X2) MULTIPLE CONSTRUCTION B. WING _____________________________

(X3) DATE SURVEY COMPLETED 05/02/2013

C. WING _____________________________

NAME OF PROVIDER OR SUPPLIER

**GOLDEN LIVINGCENTER - CHARLOTTE**

STREET ADDRESS, CITY, STATE, ZIP CODE

2616 E 5TH ST

CHARLOTTE, NC  28204

(X4) ID PREFIX TAG

F 000 INITIAL COMMENTS

No deficiencies cited as result of complaint investigation event ID# IU2Y11.

F 000 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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.