**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING**

**B. WING**

**DATE SURVEY COMPLETED**

C

11/07/2013

**NAME OF PROVIDER OR SUPPLIER**

GASTONIA HEALTHCARE AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

416 N HIGHLAND ST

GASTONIA, NC 28052

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<td>F 000</td>
<td><strong>INITIAL COMMENTS</strong></td>
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No deficiencies were cited as result of the complaint investigation. Event ID #4UHK11.

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

**TITLE**

**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.