**Statement of Deficiencies and Plan of Correction**

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**Provider/Supplier/CLIA Identification Number:**

- A. Building:
  - 34564

- B. Wing:

**Date Survey Completed:** 04/12/2018

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**Name of Provider or Supplier:** Sharon Towers

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

5100 Sharon Road
Charlotte, NC 28210

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<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>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td><strong>INITIAL COMMENTS</strong></td>
<td>F 000</td>
<td></td>
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<tr>
<td></td>
<td>This facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey).</td>
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</tbody>
</table>

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**Laboratory Director's or Provider/Suppliers Representative's Signature:**

Electronically Signed

04/17/2018

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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*Note: The table above represents a section of the document where deficiencies and plans of correction are listed, but the specific deficiencies and corrective actions are not detailed in this excerpt.*