**ACCORDIUS HEALTH AT GASTONIA**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
416 N HIGHLAND STREET
GASTONIA, NC  28052

### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>INITIAL COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td></td>
<td>A complaint investigation was conducted 01/19/21 with exit from the facility on 01/19/21. Additional information was obtained through 01/27/21. Therefore the exit date was changed to 01/27/21. 4 of 4 allegations were unsubstantiated. Event ID #6CXV11.</td>
</tr>
</tbody>
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**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**
Electronically Signed

**DATE**
02/08/2021

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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.