

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2021
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NAME OF PROVIDER OR SUPPLIER SOUTHMINSTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8919 PARK ROAD CHARLOTTE, NC 28210
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(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) COMPLETE DATE
L 000	<p>INITIAL COMMENTS</p> <p>An onsite complaint investigation survey was conducted on 06/16/21 with exit from the facility on 6/16/21. Additional information was obtained on 06/17/21. Therefore, the exit date was changed to 06/17/21. There were two allegations investigated and they were both unsubstantiated. Event ID# 6Z3011</p>	L 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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