## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345441	B. WING_	B. WING		C			
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			04/10/2019		
AL EVAND	DIA DI ACE			1770 OAK	HOLLOW ROAD				
ALEXAND	RIA PLACE			GASTONIA, NC 28054					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 000	INITIAL COMMENTS		F	000					
	No deficiences were complaint investigation	cited as a result of the in. Event ID: 54KD11.							
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RF		TITLE		(X6) DATE		

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

(X6) 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.

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Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  ALEXANDRIA PLACE  1770 OAK HOLLOW ROAD GASTONIA, NC 28054  ((A4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUlatory or LSC IDENTIFYING INFORMATION)  L 000 INITIAL COMMENTS  No deficiencies were cited as a result of the complaint investigation. Event ID 8U2511.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED									
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1770 OAK HOLLOW ROAD  GASTONIA, NC 28054   (X4) ID PREFIX TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  L 000 INITIAL COMMENTS  No deficiencies were cited as a result of the	NH0547			B. WING										
ALEXANDRIA PLACE  GASTONIA, NC 28054  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  L 000 INITIAL COMMENTS  No deficiencies were cited as a result of the	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE													
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	L 000	INITIAL COMMENTS		L 000										
		No deficiencies were	cited as a result of the											

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE