

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 05/20/2025
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NAME OF PROVIDER OR SUPPLIER ALPHA CARE ONE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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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
{C 000}	<p>Initial Comments</p> <p>Report of a Biennial Follow Up Construction Survey by Ryan Meyer conducted on May 20, 2025.</p> <p>All deficiencies have been corrected. No further action required.</p>	{C 000}		

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