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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:
345130

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _______________________
B. WING _________________________

(X3) DATE SURVEY COMPLETED
C
01/30/2013

NAME OF PROVIDER OR SUPPLIER
AVANTE AT CONCORD
STREET ADDRESS, CITY, STATE, ZIP CODE
515 LAKE CONCORD RD
CONCORD, NC 28025

(X4) ID PREFIX TAG
F 000

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LCS IDENTIFYING INFORMATION)

ID PREFIX TAG
F 000

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000

INITIAL COMMENTS
No deficiencies were cited as a result of a complaint survey on 1/30/13 Event ID# 1PMR11.

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

TITLE

(X0) 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.