STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345420

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

04/21/2018

NAME OF PROVIDER OR SUPPLIER

ALAMANCE HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1987 HILTON STREET
BURLINGTON, NC  27217

(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) COMPLETION DATE

F 000 INITIAL COMMENTS

No deficiencies were cited as a result for the complaint investigation Event ID # GUZZ11.

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

Electronically Signed

04/23/2018

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.

FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: GUZZ11
Facility ID: 932930
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