A. BUILDING ________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345420

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
R-C 10/03/2018

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

(F000) INITIAL COMMENTS

F 000

A follow up survey Event ID. YWEU12 was conducted on 10/3/18 follow was effective 9/24/18.

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

Electronically Signed
10/04/2018

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.