STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345441

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

(X3) DATE SURVEY COMPLETED

C 01/14/2019

STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054

(X4) ID PREFIX TAG
F 000 INITIAL COMMENTS

No deficiencies cited as result of survey event ID# 1O3611.

F 000

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

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

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.
## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**
345441

**Date Survey Completed:**
01/14/2019

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**Summary Statement of Deficiencies**

**F 000 INITIAL COMMENTS**

On 1/14/19 the Division of Health Service Regulation, Nursing Home Certification Section, conducted an onsite follow-up survey and complaint investigation. The facility is in compliance as of 12/14/18.

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