**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING ________________________**

**IDENTIFICATION NUMBER:** 345420

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**B. WING _____________________________**

**DATE SURVEY COMPLETED**

11/30/2019

**NAME OF PROVIDER OR SUPPLIER**

ALAMANCE HEALTH CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1987 HILTON STREET

BURLINGTON, NC  27217

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**ID**

**PREFIX**

**TAG**

**IDENTIFICATION**

**ACTION**

**COMPLETION DATE**

F 000  INITIAL COMMENTS  F 000

A complaint investigation was conducted on 11/30/19. The seven allegations were unsubstantiated.

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

Electronically Signed 12/03/2019

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.

**Event ID:** J04H11  **Facility ID:** 932930  **If continuation sheet Page:** 1 of 1