**STATION OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**ALLEGHANY CENTER**

<table>
<thead>
<tr>
<th>STRENGTH ADDRESS, CITY, STATE, ZIP CODE</th>
<th>179 COMBS STREET</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPARTA, NC 28675</td>
<td></td>
</tr>
</tbody>
</table>

**ID** | **PREFIX** | **TAG**
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F 000 | INITIAL COMMENTS | F 000

An onsite complaint investigation was conducted on 12/05/19. There was a total of 4 allegations, 2 allegations were substantiated without citation and 2 allegations were unsubstantiated. The facility remains in compliance effective 10/23/19. Event ID UD8H11.

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

**TITLE**

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**Electronically Signed**

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.