# Statement of Deficiencies and Plan of Correction

**Date Survey Completed**: 07/16/2021

## Provider Information
- **Provider/Supplier/CLIA Identification Number**: 345420
- **Name of Provider or Supplier**: Alamance Health Care Center
- **Street Address, City, State, Zip Code**: 1987 Hilton Road, Burlington, NC 27217

## Summary Statement of Deficiencies

**Event ID**: HJ1H11

- The complaint investigation survey was conducted from 7/14/21 through 7/16/21. Event ID# HJ1H11. 44 of the 44 complaint allegations were not substantiated.

## Provider's Plan of Correction

Each corrective action should be cross-referenced to the appropriate deficiency.

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**Initial Comments**

- The complaint investigation survey was conducted from 7/14/21 through 7/16/21. Event ID# HJ1H11. 44 of the 44 complaint allegations were not substantiated.

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**Laboratory Director's or Provider/Supplier Representative's Signature**

**Date**: 07/20/2021

*Electronically Signed*

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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.