A. BUILDING _____________________________

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

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

(X3) DATE SURVEY COMPLETED
C 05/04/2022

NAME OF PROVIDER OR SUPPLIER
ALAMANCE HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1987 HILTON ROAD
BURLINGTON, NC  27217

(X4) ID PREFIX TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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

(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

An onsite complaint investigation survey was conducted in conjunction with a revisit survey (Event ID# 9UBI12) from 5/3/22 through 5/4/22. The following intakes were investigated: NC00188419; NC00187959; and NC00188377. One (1) of the 4 complaint allegations was substantiated but did not result in a deficiency.

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

05/12/2022

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.