

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL076032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 10/23/2024
NAME OF PROVIDER OR SUPPLIER NORTH POINTE ASSISTED LIVING OF ARCHD,			STREET ADDRESS, CITY, STATE, ZIP CODE 303 ALDRIDGE ROAD ARCHDALE, NC 27263		
(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) COMPLETE DATE	
{C 000}	Initial Comments Report of a Construction Section Biennial Follow Up Survey conducted by Tod Hancock on October 23, 2024. Deficiencies have been corrected. No further action is necessary.	{C 000}			

Division of Health Service Regulation

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

TITLE

(X6) DATE