

Division of Health Service Regulation

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|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL080027</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____                                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>08/14/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALPHA CONCORD PLANTATION</b> |                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2809 OLD CONCORD ROAD</b><br><b>SALISBURY, NC 28146</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                           | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| {C 000}                                                             | <p>Initial Comments</p> <p>Report of a Biennial Follow Up Construction Survey by Ryan Meyer conducted on August 14, 2025.</p> <p>All deficiencies have been corrected. No further action required.</p> | {C 000}                                                                                             |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE