

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL097016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 06/04/2024
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NAME OF PROVIDER OR SUPPLIER WILKESBORO ASSISTED LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 206 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659
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(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}	<p>Initial Comments</p> <p>Based on documentation received on May 8, 2024, all deficiencies have been corrected and no further action is required.</p>	{C 000}		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____