

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL005013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 07/16/2019
NAME OF PROVIDER OR SUPPLIER ASHE ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 182 CHATTYROB LANE WEST JEFFERSON, NC 28694		
(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 Biennial Follow Up Construction Survey by Dennis Harrell on 7-16-2019. A deficiency was not properly corrected. Further action is required.	{C 000}		
{C 189}	Building Equipment Maintained Safe, Operating SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: New Citation Based on observation, the Building was not maintained in a safe condition, because of an exit door that was very hard to open. Exit doors that will not open easily could delay or prevent an evacuation in an emergency. New Finding on 7-16-2019; The exit door near the Nurse office was very hard to open requiring a force in excess of 100 pounds.	{C 189}		

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

TITLE

(X6) DATE