

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL005018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 04/10/2024
NAME OF PROVIDER OR SUPPLIER ASHE FAMILY CARE HOME # 1			STREET ADDRESS, CITY, STATE, ZIP CODE 523 MILT HOUCK ROAD TODD, 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 by Kelly Myers DHSR Construction Section conducted a Biennial Follow-up Survey on April 10, 2024, from 9:55 AM to 10:30 AM at the above referenced facility. At the time of the survey all deficiencies noted in the Biennial Survey were corrected therefore no further action is required.	{C 000}			

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

TITLE

(X6) DATE