

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL046020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER AHOSKIE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910		
(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 Suzanna Fay of a Follow Up Construction Survey by Documentation on August 27, 2025. Based on documentation received by this office on August 19, 2025, all previously cited deficiencies have been corrected or will be corrected by August 31, 2025. Therefore, no further action is required at this time.	{C 000}		

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

TITLE

(X6) DATE