

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL046004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/14/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AHOSKIE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>407 LOFTIN LANE</b> <b>AHOSKIE, NC 27910</b>
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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>Report of a Biennial Follow Up Construction Survey by Suzanna Fay conducted on January 14, 2025.</p> <p>Deficiencies noted during the Biennial Construction Survey have been corrected and no further action is required at this time.</p>	{C 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_