STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL059019	A. BUILDING: **01** B. WING _____	R **03/19/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY PASS FAMILY CARE HOME	**5349 NC 226 SOUTH MARION, NC 28752**

(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 Luis Padilla DHSR Construction Section conducted a Biennial Follow-up Survey on March 19, 2019 from 1:30 PM to 1:45 PM at the above referenced facility. Not all of the previously cited deficiencies were corrected. Therefore, further action is required. The remaining deficiencies are as follows:	{C 000}		
{C 131}	Building Service Equipment-Call System IV. The Building D. Building Service Equipment (10 NCAC 42C .2214) 5. Where the bedroom of the live-in staff is located in a separate area from residents' bedrooms, an electrically operated sounding device must be provided connecting each resident bedroom to the live-in staff bedroom. The resident call switches, must be such that they can be activated with a single action and remain on until switched off by staff. The call switch must be within reach of the resident lying on his/her bed. This Rule is not met as evidenced by: 1.) The rule requires where the bedroom of the live-in staff is located in a separate area from residents' bedrooms, an electrically operated sounding device must be provided connecting each resident bedroom to the live-in staff bedroom. The resident call switches, must be such that they can be activated with a single action and remain on until switched off by staff. The call switch must be within reach of the resident lying on his/her bed: During our visit it was observed that Bedroom #3	{C 131}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL059019	A. BUILDING: **01** B. WING _____	R **03/19/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY PASS FAMILY CARE HOME	**5349 NC 226 SOUTH MARION, NC 28752**

(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 131}	Continued From page 1 is remote from the staff bedroom which will require a call system for this room and staff quarters that complies with the rule. Make arrangements to have the deficiency corrected; provide documentation in the form of photos/invoices for all completed work. 3/19/2019-LAP Based on observation and distance Bedroom #3 is remote from the staff bedroom which will require a call system for this room and staff quarters that complies with the rule. Taken action to provide an electrically operated (wired or wireless) call system that comply's with the rule.	{C 131}		