

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2019
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 817 SOUTH SECOND STREET SMITHFIELD, NC 27577		
(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 The Adult Care Licensure Section conducted an annual survey and complaint investigation on September 10-11, 2019.	C 000		
C 069	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a sounding device was activated on 3 of 3 exit doors to alert staff when 2 of 3 sampled residents documented as being intermittently disoriented (Residents #1 and #3) exited the facility. The findings are: Observation, upon entrance to the facility, on 09/10/19 at 9:15am revealed the kitchen door was opened and there was no sounding device heard when the when the glass storm door was opened. Observation of the exit door next to the laundry	C 069		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2019
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 817 SOUTH SECOND STREET SMITHFIELD, NC 27577		
(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 069	Continued From page 1 room on 09/10/19 during the initial tour between 10:00am and 10:30am revealed there was no audible sounding devices when the door was opened. Observation of the front exit door close to Resident #1's bedroom on 09/10/19 at 1:45pm revealed there was no audible sounding devices when the door was opened. 1. Review of Resident #1's current FL-2 dated 05/13/19 revealed: -Diagnoses included hypertension, diabetes, schizoaffective disorder, bipolar type, hyperlipidemia, and diabetic neuropathy. -There was documentation the resident was intermittently disoriented. Review of a guardianship document in Resident #1's record revealed: -Resident #1 was adjudicated incompetent. -A county Department of Social Services was appointed as guardian of the person. Review of the Resident Register for Resident #1 (signed but not dated) revealed: -The resident was forgetful and needed reminders. -The resident required assistance for orientation to time and place. Review of Resident #1's Care Plan dated 12/13/18 revealed the resident was assessed as forgetful and needing reminders. Review of the most recent licensed health professional support evaluation dated 08/10/19 revealed Resident #1 continued to require periodic redirection.	C 069		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2019
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 817 SOUTH SECOND STREET SMITHFIELD, NC 27577		
(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 069	Continued From page 2 Interview with the Resident Care Coordinator/Supervisor (RCC/Supervisor) on 09/10/19 at 12:10pm revealed: -There were no audible alarms on the exit doors at the facility. -There were no residents at the facility who were known to be disoriented. Second interview with the RCC/Supervisor on 09/10/19 at 1:45pm revealed: -She thought she had looked at the section of Resident #1's FL-2 that listed the resident as intermittently disoriented but mistook that section for indicating the resident's level of toileting function. -Staff used to check off on the FL-2 that a resident was disoriented if the resident was confused. -She thought the primary care provider completed the "Patient Information" section of the FL-2. Interview with the Administrator on 09/10/19 at 2:10pm revealed: -She was aware of the rule about "constantly disoriented or wanderers" requiring a sounding device on the exit doors. -There were sections on the FL-2 that provided information. -The facility used the physician orders and FL-2 to formulate a plan of care for the residents. Attempted telephone interview with Resident #1's primary care provider on 09/10/19 at 2:50pm was unsuccessful. Refer to the interview with the RCC/Supervisor on 09/10/19 at 1:45pm. Refer to the interview with the Administrator on 09/10/19 at 2:10pm.	C 069		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2019
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 817 SOUTH SECOND STREET SMITHFIELD, NC 27577		
(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 069	Continued From page 3 2. Review of Resident #3's current FL-2 dated 04/16/19 revealed: -Diagnoses included bipolar disorder, leukopenia, and schizoaffective disorder. -There was documentation the resident was intermittently disoriented. Refer to the interview with the RCC/Supervisor on 09/10/19 at 1:45pm. Refer to the interview with the Administrator on 09/10/19 at 2:10pm. Interview with the RCC/Supervisor on 09/10/19 at 1:45pm revealed: -She could not recall but remembered the facility having alarms around 2 years ago. -Two years ago, alarms would alert when front and back door were being used. -The facility did not have any residents who had wandering behaviors. -She was keeping an eye on the residents. -No one used the front door. -She recalled wiring and battery issues with the previous alarm. -The alarm was loud and waking the residents at night. -She reported the alarm being loud and waking the residents up at night. -The door alarms were checked by the fire marshal because they were going off, and that was the last time she remembered hearing the door alarm sounding device. -She was not aware there was a rule requiring the facility to have a sounding device on the doors if there were residents who were disoriented. Interview with the Administrator on 09/10/19 at 2:10pm revealed: -There were no alarms on the exit doors.	C 069		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2019
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 817 SOUTH SECOND STREET SMITHFIELD, NC 27577		
(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 069	Continued From page 4 -If the facility had wanderers, then the alarms would be used. -There were no reports of residents walking out of the facility. -She would only consider getting door alarms if she received consistent reports of wandering from staff. -If safety was questionable then she would consider using alarms. -She was aware of the rule about "constantly disoriented or wanderers" requiring a sounding device on the exit doors. -There were sections on the FL-2 that provided information. -The facility used the physician orders and FL-2 to formulate a plan of care for the residents.	C 069		
C 176	10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation Each family care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. If the only staff person on site has been deemed physically incapable of performing these procedures by a licensed physician, that person is exempt from the training.	C 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2019
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 817 SOUTH SECOND STREET SMITHFIELD, NC 27577		
(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 176	Continued From page 5 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure at least one staff member was on duty who had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR). The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired 03/20/19 as the main live in staff. -There was no documentation Staff B had completed CPR training within the last 24 months. -There was documentation of completion of CPR training on 01/03/17. Attempted telephone interview with Staff B on 09/11/19 at 1:43 pm was unsuccessful. Interview with the Administrator on 09/10/19 at 2:30pm revealed: -Staff records were checked every quarter to ensure compliance. -Records were reviewed two weeks during the process of thinning personnel charts and during that time, she identified some of the information missing. -That was when she realized Staff B did not have current CPR certification. -The CPR training was only a renewal and the knowledge remained, although the CPR had expired. -In an emergency, she expected staff to use the knowledge they had to address the emergency and call emergency management and supervisory staff. 2. Review of the Resident Care	C 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2019
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 817 SOUTH SECOND STREET SMITHFIELD, NC 27577		
(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 176	Continued From page 6 Coordinator/Supervisor (Staff A) personnel record revealed: -There was a hire date of 05/20/16. -There was documentation of successfully completing a CPR course on 08/29/17 which was valid for 2 years. -There was no documentation Staff A had completed CPR training within the last 24 months. Interview with Staff A on 09/10/19 at 9:30am revealed: -She was a supervisor and medication aide for the facility. -She was the relief live-in staff for the facility. -She was currently the live-in staff on duty for the facility. -The "main" live-in staff stayed in the facility for three weeks and then off one week. -Six residents lived in the facility. -Five residents were at a day program. -There was one resident at the facility today. -The facility was in the process of getting the resident, who was at the facility today, in to a day program. Interview with the Administrator on 09/10/19 at 3:30pm revealed: -She recently found out Staff A's CPR had expired. -The facility had planned for a CPR class to be conducted on 09/06/19 but due to weather conditions, the trainer was not able to come to the facility. -The facility had rescheduled the CPR class for 09/09/19 but the trainer was not able to come to the facility to conduct the CPR class. Interview with Staff A on 09/10/19 at 3:35pm revealed:	C 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2019
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 817 SOUTH SECOND STREET SMITHFIELD, NC 27577		
(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 176	Continued From page 7 -She found out her CPR had expired one day last week when she and facility staff were transferring personnel records from folders to notebooks. -She had not been told prior to last week that her CPR training needed renewal. Second interview with the Administrator on 09/11/19 at 2:30pm revealed: -She checked staff records quarterly. -She had reviewed staff personnel records two week ago. -In an emergency she would have expected staff to use the knowledge they had to address the emergency and call emergency management and supervisory staff. The facility failed to assure there was one staff member on duty in the facility at all times who had completed a course on CPR and choking management within the last 24 months. The facility's failure was detrimental to the health and safety of the resident in the event of an emergency requiring CPR or management of a choking resident. This non-compliance constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/10/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 25, 2019.	C 176		
C 272	10A NCAC 13G .0904(d)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service	C 272		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2019
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 817 SOUTH SECOND STREET SMITHFIELD, NC 27577		
(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 272	Continued From page 8 (d) Food Requirements in Family Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure snacks were offered or made available to all residents three times a day. The findings are: Review of the facility's posted week three menu revealed: -There were no listed snacks or snack options to be served. -There were no times listed for snacks to be served. Interview with a resident on 09/10/19 at 10:20am revealed: -He got a snack "before dark". -If he asked staff for a snack, the staff would give him a snack. Interview with the Resident Care Coordinator/Supervisor (RCC/Supervisor) on 09/10/19 at 10:30am revealed: -Snacks were made available at 3:00pm-3:20pm when the residents at the day program returned to the facility. -Residents were provided snacks at other times if the residents asked for a snack. -Sometimes after dinner, a resident would ask for a snack. -There was one resident (named) who was typically asked if he wanted a snack after the	C 272		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2019
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 817 SOUTH SECOND STREET SMITHFIELD, NC 27577		
(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 272	Continued From page 9 dinner meal. -There was no specific time of the day that snacks were offered. Observation of a resident on 09/10/19 at 11:05am revealed the RCC/Supervisor served the resident a bag of popcorn and water. Observation of available snacks on 09/10/19 at 3:15pm revealed: -The RCC/S laid individual bags of cheese doddles on the kitchen countertop. -Two of the six residents in the facility took a bag of the snack left on the kitchen countertop. Interview with a second resident on 09/10/19 at 4:20pm revealed: - Snacks were offered twice a day. - Snacks were provided at night time. - Snacks were given after he returned from the day program. Interview with a third resident on 09/10/19 at 4:27pm revealed: -Snacks were given twice a day. -Snacks were given in the evening when he returns from the day program. -Snacks were given at bed time. Interview with a fourth resident on 09/10/19 at 4:30pm revealed: -He got a snack when he returned to the facility from the day program. -He got one snack a day. -He could get a snack if he wanted a snack. Interview with fifth resident on 09/10/19 at 4:36pm revealed: -Snacks were given twice a day. -Snacks were given in the afternoon when he	C 272		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2019
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 817 SOUTH SECOND STREET SMITHFIELD, NC 27577		
(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 272	Continued From page 10 returned from the day program and at bedtime. Interview with a sixth resident on 09/10/19 at 4:37pm revealed: -Sometimes he got a snack. -He would like to get more snacks. -He could get another snack "sometimes" if he asked. Interview with the RCC/Supervisor on 09/11/19 at 12:06pm revealed: -She did not know the dietician prepared menus used by the facility were supposed to list snacks. -She usually alternated crackers and chips for snacks. -She knew residents were supposed to have snacks three times a day. -The residents at that facility were very verbal and would ask for snacks. Interview with the Administrator on 09/11/19 at 2:40pm revealed: -The residents were supposed to get two snacks daily - one when they returned from the day program, and one at night. -Snacks were offered, and if not getting offered, they should be. -The residents should not be asking for a snack.	C 272		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	C 912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2019
NAME OF PROVIDER OR SUPPLIER ULTIMATE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 817 SOUTH SECOND STREET SMITHFIELD, NC 27577		
(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 912	Continued From page 11 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to training on cardio-pulmonary resuscitation. The findings are: Based on observations, record reviews and interviews, the facility failed to assure at least one staff person was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR). [Refer to Tag 176, 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)].	C 912		