STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045104	A. BUILDING: _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAY FAMILY CARE	337 OVERLOOK TERRACE HENDERSONVILLE, NC 28739

(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 with an onsite visit on 03/24/21 and a telephone exit on 03/25/21.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to notify the primary care provider (PCP) of two incidents of choking on food which required staff to perform the Heimlich Maneuver and one incident of choking on water for 1 of 3 sampled residents (Resident # 2). The findings are: Review of Resident #2's current FL2 dated 05/04/20 revealed: -Diagnoses included dysphagia with aspiration, schizophrenia, and diabetes mellitus type II. -There was an order for a regular diet. -There was an order to eat sitting up with chin tuck. -There was an order to drink best tolerated through a straw, chokes unless drinks with a straw. -There was an order for aspiration precautions. Review of Resident #2's Resident Register revealed: -The resident was admitted to the facility on 11/02/16.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045104	A. BUILDING: _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAY FAMILY CARE	337 OVERLOOK TERRACE HENDERSONVILLE, NC 28739

(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 246	Continued From page 1 -The resident had a guardian. Review of Resident #2's Care Plan dated 05/04/20 revealed the resident required supervision with eating. Review of Resident #2's physician orders dated 10/13/20 revealed: -There was an order to eat sitting up with chin tuck. -There was an order to drink best tolerated through a straw, chokes unless drinks with a straw. -There was an order for aspiration precautions. Interview with a Supervisor-In-Charge (SIC) on 03/24/21 at 8:45am revealed: -Resident #2 had a history of choking. -Resident #2's meats were cut before serving due to choking precautions -Resident #2 had to drink liquids through a straw due to choking precautions. -She had to remain in the room while Resident #2 ate his meals. Review of Resident #2's progress note dated 08/18/20 revealed: -Resident #2 "choked badly" at breakfast. -The Heimlich Maneuver was required to remove the food. Review of Resident #2's physician visit note dated 10/06/20 revealed there was an order to apply choking precautions each meal and to drink with a straw with head down. Review of Resident #2's progress note dated 02/26/21 revealed Resident #2 had a "choking incident" at dinner.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045104	A. BUILDING: _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAY FAMILY CARE	337 OVERLOOK TERRACE HENDERSONVILLE, NC 28739

(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 246	Continued From page 2 Review of Resident #2's progress note dated 02/27/21 revealed: -Resident #2 had complained to staff of having "pains in his ribs." -Resident #2 had said the pains in his ribs were due to "being attended to" by staff after "choking from a piece of meat." Review of Resident #2's physician visit note dated 03/04/21 revealed: -There was an order to verbally remind Resident #2 before each meal to eat slowly; small bites, use knife and fork, cut food, swallow with chin down, use straw 100% to drink, with chin down. Review of Resident #2's progress note dated 03/11/21 revealed: -Resident #2 had a "choking incident" at dinner. -Resident #2 was drinking water without a straw "though he had a straw in the juice in front of him." Interview with the SIC on 03/24/21 at 11:00am revealed: -Resident #2 "tends" to eat really fast. -Resident #2 had orders to use a straw for drinking all beverages. -She sat with Resident #2 to monitor the speed with which he ate his meals, size of the bites of food the resident ate, and ensured the resident used a straw to drink beverages. -She did not know if Resident #2 had ever had a swallowing study. -Resident #2 had choked on food on 02/26/21, requiring her to perform the Heimlich Maneuver. -When Resident #2 had choked on 02/26/21, he had been able to stand as she performed the Heimlich Maneuver. -After she had successfully dislodged the food, Resident #2 had walked to the bathroom with her	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045104	A. BUILDING: _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAY FAMILY CARE	337 OVERLOOK TERRACE HENDERSONVILLE, NC 28739

(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 246	Continued From page 3	C 246		

and spit out the food.
-She had not called emergency medical services.
-Resident #2 had not gone to the hospital for evaluation.
-She had called the Guardian to notify her of the choking incident.
-The Guardian did not want Resident #2 to be evaluated after the incident.
-She had called the Administrator to notify her of the choking incident.

Interview with the Administrator on 03/24/21 at 12:37pm revealed:
-Resident #2 choked at breakfast on 08/18/20, requiring the SIC to perform the Heimlich Maneuver.
-The SIC had notified her of the incident and Resident #2's Guardian.
-The Guardian had not wanted Resident #2 sent to the hospital for evaluation after the choking incident on 08/18/20.
-She was not sure if a swallowing study had been performed in the past, she had "followed the guidance" of the Guardian.
-The physician who saw Resident #2 on 10/06/20 and 03/04/21 was a retired physician who had been Resident #2's physician before she had retired.
-When Resident #2 choked on 02/26/21 requiring the SIC to perform the Heimlich Maneuver, the SIC notified the Guardian who had been communicating with the physician who had seen the resident on 10/06/20 and 03/04/21, and did not recommend sending him for evaluation at the hospital.

Telephone interview with Resident #2's Guardian on 03/24/21 at 12:45pm revealed:
-Resident #2's swallowing problems were caused by the resident eating "too fast", because he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045104	A. BUILDING: _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAY FAMILY CARE	337 OVERLOOK TERRACE HENDERSONVILLE, NC 28739

(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 246	Continued From page 4	C 246		

"afraid" someone was going to take food from him.
-She spoke with Resident #2 "daily" to remind him to follow eating and drinking precautions.
-Resident #2 had a swallowing study at a local hospital, but it had been "awhile."
-The swallowing study had shown there was nothing physically wrong with Resident #2's swallowing ability.
-Resident #2 had to eat small bites and use a straw.
-She had been informed of the choking incidents on 08/18/20 and 02/26/21 by the SIC.
-She had been informed of the choking incident on 03/11/21 with water and "sometimes" it happened with the resident's own "spit."
-She had not wanted Resident #2 sent out for evaluation after any of the choking incidents.
-The physician who came to the facility to see Resident #2 on 10/06/20 and 03/04/21 was a retired Internist and saw Resident #2 on a volunteer basis.

Interview with Resident #2 on 03/24/21 at 2:45pm revealed:
-He did not remember choking on 08/18/20.
-He had not seen his primary care physician since "last year."

Interview with the SIC on 03/24/21 at 2:55pm revealed:
-Resident #2 was on a regular diet.
-She cut up all of Resident #2's meats into bite size "chunks" except for fish.
-The choking incidents on 08/18/20 and 02/26/21 were the only incidents of choking Resident #2 had experienced since she had started working in the facility 2 years prior.
-She had notified the Guardian and Administrator about the choking incident on 02/26/21 and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045104	A. BUILDING: _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAY FAMILY CARE	337 OVERLOOK TERRACE HENDERSONVILLE, NC 28739

(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 246	Continued From page 5 Guardian did not want Resident #2 sent out for evaluation. Telephone interview on 03/24/21 at 4:05pm with the attending medical provider for Resident #2 revealed: -She was Resident #2's "consulting internist." -The primary care physician (PCP) would have to give an order for any diet order changes. -She came every 3 weeks to the facility to administer injections to Resident #2. -Resident #2 had a swallowing study in the past. -The swallowing study had shown the resident should have thickened liquids or drink liquids with a straw. -Resident #2 had been "choking for decades." -She had Heimliched him, his Guardian had Heimliched him, it was a "long standing issue." -She had visited Resident #2 on 03/04/21 after his last choking episode on 02/26/21. Telephone interview with Resident #2's PCP on 03/24/21 6:41pm and on 03/25/21 at 12:04pm revealed: -He was the PCP for Resident #2. -He had not seen Resident #2 since the COVID-19 pandemic began due to his Guardian's concerns over COVID-19. -He needed to see Resident #2 for all of his health issues since he had not seen the resident in "over a year." -He had not been notified of the choking episodes which occurred on 08/18/20, 02/26/21, and 03/11/21. -He could not make recommendations as to what to do about the choking or diet order changes without doing a swallowing study. _____ The facility failed to notify the primary care physician of two episodes of choking on food	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045104	A. BUILDING: _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAY FAMILY CARE	337 OVERLOOK TERRACE HENDERSONVILLE, NC 28739

(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 246	Continued From page 6 requiring the Heimlich Maneuver and one episode of choking on water (Resident #2). This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/24/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 9, 2021.	C 246		
C 611	10A NCAC 13G .1701 (b) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following: (1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal	C 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045104	A. BUILDING: _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAY FAMILY CARE	337 OVERLOOK TERRACE HENDERSONVILLE, NC 28739

(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 611	Continued From page 7 protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1702 of this Section; (3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen; (4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures; (5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working; (6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak; (7) The annual review and update of the facility ' s IPCP to be consistent with published CDC	C 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045104	A. BUILDING: _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAY FAMILY CARE	337 OVERLOOK TERRACE HENDERSONVILLE, NC 28739

(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 611	Continued From page 8 guidance on infection control; and (8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 6 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of residents, staff, and visitors. The findings are: Review of the CDC guidelines for the prevention and spread of COVID-19 in long-term care (LTC) facilities last updated 11/20/20 revealed: -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -Personnel should be screened for fever and symptoms of COVID-19 before starting each shift. -Screen residents daily for fever and symptoms of COVID-19.	C 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045104	A. BUILDING: _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAY FAMILY CARE	337 OVERLOOK TERRACE HENDERSONVILLE, NC 28739

(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 611	Continued From page 9 Review of the NCDHHS guidance for the prevention and spread of COVID-19 in LTC facilities dated 09/2020 revealed: -Actively screen all residents at least daily for fever and respiratory symptoms. -All visitors to the facility should be screened for signs and symptoms of COVID-19 prior to entering the facility. Observations upon entering the facility on 03/24/21 at 8:40am revealed: -The supervisor in charge (SIC) met the surveyors at the office door. -There was a no-touch thermometer on a shelf in the office. -The SIC did not offer or request to check the surveyors temperature or ask any screening questions upon entry. Interview with the SIC on 03/24/21 at 8:41am revealed: -She did not think she needed to screen the surveyors as they were "from the state" and assumed they were "okay". -The facility had stopped visitation after the pandemic started. Interview with two residents on 03/24/21 at 9:04am revealed COVID-19 temperature checks were not being conducted on them. Interview with another resident on 03/24/21 at 9:10am revealed COVID-19 temperature checks were not being conducted on him. Interview with the Administrator on 03/24/21 at 9:55am and 4:08pm revealed: -The SIC lived at the facility. -The facility conducted temperature checks at the	C 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045104	A. BUILDING: _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAY FAMILY CARE	337 OVERLOOK TERRACE HENDERSONVILLE, NC 28739

(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 611	Continued From page 10 beginning of the pandemic but since they were "grounded" they stopped taking resident temperatures because no one was being exposed to COVID-19. -All residents and staff had been vaccinated for COVID-19 and the second dose was administered on 02/08/21. -All visitors were screened but visitors were rare. -The weekend relief staff had her temperature taken at the beginning of her shift but they did not document it. -No documentation of any screening was kept because she did not see a need since screening was so rare. -She thought that all the e-mails she received in reference to screening pertainied to large facilities that had rotating staff, not a family care home like this one where everyone lived at the facility all the time.	C 611		
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. 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 are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to healthcare. The findings are:	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045104	A. BUILDING: _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAY FAMILY CARE	337 OVERLOOK TERRACE HENDERSONVILLE, NC 28739

(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 Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider (PCP) of two incidents of choking on food which required staff to perform the Heimlich Maneuver and one incident of choking on water for 1 of 3 sampled residents (Resident # 2).[Refer to Tag 246, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	C 912		