

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL059019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/21/2015
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NAME OF PROVIDER OR SUPPLIER ROCKY PASS FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 5349 NC 226 SOUTH MARION, NC 28752
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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
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C 000	<p>Initial Comments</p> <p>Report by Glenn Hoppin</p> <p>DHSR Construction Section conducted a Complaint Survey on October 21, 2015 from 8:30AM to 9:30AM at the above referenced facility. DHSR records indicate the home was first licensed on November 24 1982 as a Family Care Home for Five Ambulatory Residents (able to evacuate and respond without any physical or verbal assistance during a fire or other emergency). Sometime after January 01, 1984 the capacity was increased to six Ambulatory Residents. Based on this information we are requiring the home to maintain compliance with the following: the 1984 "Rules for Family Care Homes Minimum and Desired Standards and Regulations", the applicable portions of the 2005 Rules 10A NCAC 13G for Family Care Homes, and the 1978 (Rev 5) North Carolina State Building Code - Section 409.1G - Residential Care Homes.</p> <p>At the time of our visit, the complaint was unsubstantiated and no further action is required.</p>	C 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____