PRINTED: 10/04/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
			A. BOILDING.									
		MHL051-218	B. WING		10/0	2/2019						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
ULTIMATE FAMILY CARE - 6 8936 NC HIGHWAY 96 SOUTH BENSON, NC 27504												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE						
V 000	INITIAL COMMENT	rs .	V 000									
	An annual survey was completed on October 2, 2019. A deficiency was cited.											
	This facility is licensed for the following service category:  10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.											
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736									
	EXTERIOR REQUI (c) Each facility and maintained in a safe	803 LOCATION AND REMENTS If its grounds shall be e, clean, attractive and orderly e kept free from offensive										
	failed to ensure fac	et as evidenced by: on and interview, the facility ility grounds were maintained I attractive manner. The										
	Dinning area revea	om dinning table were										
	Living area reveale -Coffee tables next off exposing bare c -Pillows from sofas the stains were cra	to TV had laminates peeled										

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL051-218	B. WING		10/0	2/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DDRESS, CITY, STATE, ZIP CODE				
ULTIMAT	E FAMILY CARE - 6		HIGHWAY 96 NC 27504	SOUTH			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE		
V 736	Continued From page 1		V 736				
	bathroom #1 reveal -Pop corn ceiling wa -There was rust on floor.  Observation on 10/2 bathroom #2 reveal -Three was grime of stallThere was rust on floor.  Observation on 10/2 revealed: -There was rust on floor.  Interview on 10/2/19 revealed: -Facility was respons maintenanceShe would let man replacing the air verShe confirmed the	as peeling off. the air vent located on the  2/19 at about 12:43 PM led: on the bottom of the shower the air vent located on the  2/19 of facility bedrooms the air vents located on the  9 with the Home Supervisor asible for doing own agement know about					

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6V5H11 If continuation sheet 2 of 2