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			
MHL069-001		B. WING		08/18/2021				
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
PAMLIC	PAMLICO COUNTY GROUP HOME 554 HIGHWAY 306 NORTH							
		GRANTSI	BORO, NC 2	8529		1		
(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 COMMENTS		V 000					
	An annual survey w 2021. A deficiency	ras completed on August 18, was cited.						
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.						
V 108	108 27G .0202 (F-I) Personnel Requirements		V 108					
	(g) Employee training provided and, at a refollowing: (1) general organiz (2) training on clier delineated in 10A Not 10A Not 26B; (3) training to meet client as specified in plan; and (4) training in infect bloodborne pathogo (h) Except as permious 5602(b) of this Submember shall be avoid times when a client member shall be traincluding seizure mound to provide cardioput trained in the Heimle techniques such as the American Heart equivalence for relicion in the policies implement policies	cation shall be documented. Ing programs shall be minimum, shall consist of the cational orientation; It rights and confidentiality as CAC 27C, 27D, 27E, 27F and It the mh/dd/sa needs of the in the treatment/habilitation tious diseases and ens. Itted under 10a NCAC 27G inchapter, at least one staff vailable in the facility at all is present. That staff ained in basic first aid anagement, currently trained anagement, currently trained anagement, currently trained anagement or other first aid those provided by Red Cross, Association or their eving airway obstruction. Inody shall develop and and procedures for identifying,						
	reporting, investigat	ting and controlling infectious diseases of personnel and						

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:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL069-001	B. WING		08/1	8/2021	
	NAME OF PROVIDER OR SUPPLIER PAMLICO COUNTY GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE 554 HIGHWAY 306 NORTH GRANTSBORO, NC 28529						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 108	Continued From pa	ge 1	V 108				
	failed to ensure star cardiopulmonary re the Red Cross, the or their equivalence	et as evidenced by: view and interview, the facility ff were currently trained in suscitation (CPR) provided by American Heart Association, e for 2 of 3 staff audited (Staff ead). The findings are:					
	revealed: - Title of Developme - Hire date 7/05/94 Training in CPR a	nd First Aid dated 10/02/19.					
	stated: - CPR/First Aid trair - CPR training parti	n 8/17/21 and 8/18/21 staff #1 ning was completed online. cipants demonstrated chest icking a computer mouse.					
	revealed: - Title of Developme - Hire date 7/20/15.						
	All training, includi completed online.CPR training parti compressions by cl	8/17/21 staff #2 stated: ng CPR and First Aid were cipants demonstrated chest icking a computer mouse. I tell you if your going too fast					

6899

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		MHL069-001	B. WING		08/1	8/2021	
	PROVIDER OR SUPPLIER COUNTY GROUP H	OMF 554 HIGH	DDRESS, CITY, STATE, ZIP CODE HWAY 306 NORTH BORO, NC 28529				
(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 108	- CPR training partiproficiency with the Defibrillator via the Review on 8/17/21 personnel record retrieved and the Title of Team Lead - Hire date 9/12/05. - Training in CPR and During interview on stated: - CPR and First Aid online. - CPR training particompressions by cluming interview on Manager stated: - CPR and First Aid online. - CPR training particompressions by clumine. - CPR training particompressions by clumine.	cipants also demonstrated Automatic External computer mouse. of the Team Leader's evealed: der.	V 108				

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