STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001133	A. BUILDING: _____ B. WING _____	08/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUR GRACE AND MERCY FAMILY CARE HOI	919 ELM STREET BURLINGTON, NC 27217

(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 on August 3. 2016.	C 000		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure each resident had tuberculosis (TB) disease testing upon admission to the facility in compliance with the control measures adopted by the Commission for Health Services for 1 (Resident #1) of 3 sampled residents. The findings are: Review of Resident #1's Resident Register revealed date of admission was 7/13/16. Review of Resident #1's record revealed documentation of no TB skin test. Interview with Resident #1 on 8/03/16 at 11:00 a.m. revealed he thought he had a TB skin test in July 2016.	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001133	A. BUILDING: _____ B. WING _____	08/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUR GRACE AND MERCY FAMILY CARE HOI	919 ELM STREET BURLINGTON, NC 27217

(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 202	Continued From page 1 Interview with the Administrator on 8/03/16 at 11:30 a.m. revealed: -She could not find documentation of a TB skin test in resident's record. -She thought Resident #1 had a TB skin test. -The Social Worker told her the resident had a TB skin test in July 2016. -The facility's monitoring plan in place for residents' TB skin test was 1st step prior to admission and the 2nd step within 2 weeks of admission. No TB skin tests were provided for Resident #1 by the end of the survey.	C 202		