Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060123	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAIN'S FAMILY CARE HOME # 1	5963 THE PLAZA ROAD CHARLOTTE, NC 28215

RECEIVED
DEC 08 2016
ADULT CARE LICENSURE SECTION RALEIGH

(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 and the Mecklenburg County Department of Social Services conducted an annual survey on November 08 and November 09, 2016.	C 000		
C 153	10A NCAC 13G .0501 (a) Personal Care Training And Competency 10A NCAC 13G .0501 Personal Care Training And Competency (a) The facility shall assure that personal care staff and those who directly supervise them in facilities without heavy care residents successfully complete a 25-hour training program, including competency evaluation, approved by the Department according to Rule .0502 of this Section. For the purposes of this Subchapter, heavy care residents are those for whom the facility is providing personal care tasks listed in Paragraph (i) of this Rule. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 3 of 3 sampled staff (Staff A, B and C) had completed the 25 hour personal care training within the first 6 months of hire. The findings are: A. Review of the personnel record for Staff A revealed: -A hire date of 01/30/16.	C 153	The facility of McClain's family Care will make sure that staff should take their training before or based on the time table or time set by the state Policy how long to complete their training. The facility staff has completed the PCS training since the 16 of Dec. 2016. From now on the facility will go by the rules and policy.	12/16/16

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Reviewed & Accepted 1-17-17 DKB

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C 153	Continued From page 1 -She was hired as a Personal Care Aide. -There was no documentation of personal care training being completed. Interview on 11/08/16 at 11:15 am with Staff A revealed: -She was hired "at the end of January or early February" as a Personal Care Aide. -She usually worked Monday through Friday, from 2 pm through 9 am the following day. -She administered medications, cooked meals, cleaned the facility and assisted the residents as needed. -Mostly the residents were independent with their Activities of Daily Living (ADL), but she did have to encourage and remind them on a regular basis. -She did have to assist one resident with showers, dressing, and putting her socks and shoes on. -She did complete the personal care training "a long time ago". -The training certificate should be in her personnel record, but if it was not there, she would look in her records at home. Refer to interview with the Administrator on 11/09/16 at 2:30 pm. B. Review of the personnel record for Staff B revealed: -A hire date of 10/09/14. -She was hired as a Personal Care Aide. -There was no documentation of personal care training being completed. Interview on 11/08/16 at 2:05 pm with Staff B revealed: -She was hired in 2014 as a Personal Care Aide. -She worked weekends.	C 153	The staff has Completed the Personal Care Aide trainy and documents has placed in her record. From now on, the facility Administrator will make sure that all documentation will be done correctly. The staff who perform duty at 2pm to 9pm monday to Friday has Completed her Personal Care Aide trainy. Staff B who work on the weekend has Completed her Personal Care trainy also her Medication Aide test be Completed and the documents is in her record. The ~~facility~~ facility administrator will Correct this mistake and will not happen again.	12/16/16 12/16/16

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C 153	Continued From page 2 -She administered medications, cooked meals, assisted the residents as needed and cleaned the facility when she worked. -The residents were mostly independent with their ADLs, but she did have to encourage and remind them to complete them. -She had not taken any personal care training classes. Refer to interview with the Administrator on 11/09/16 at 2:30 pm. C. Review of the personnel record for Staff C revealed: -A hire date of 01/15/14. -She was hired as a Personal Care Aide. -There was no documentation of personal care training. Interview on 11/08/16 at 11:00 am with Staff A, Personal Care Aide, revealed Staff C worked evenings and weekends as a Personal Care Aide. Staff C was unavailable for interview during the survey. Refer to interview with the Administrator on 11/09/16 at 2:30 pm. Interview with the Administrator on 11/09/16 at 2:30 pm revealed: -The Administrator was responsible for making sure all required information was in the personnel records. -He was not aware the of the requirement for personal care training if staff provided personal care assistance.	C 153	The facility Administrator has taken a Serious take how this mistake will not happen again. The staff in question has take her PCS training and also her medication test. All the staff have Completed the Personal Care Aide training. Staff A, Personal Care Aide and Staff C work evenings and weekend as a Personal Care Aide Provider has Completed the training. The facility administrator will not allow for such a mistake to occure in the future again. As an Administrator fully aweared that all staffs Should be traing as a Personal Care Aide before work in the home. That	12/16/16 12/16/16

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C 202	Continued From page 3	C 202	rule will be followed, and make sure staff will be onform too about these rule	
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: TYPE B VIOLATION Based on record review and interview, the facility failed to assure 1 of 3 sampled residents (Resident #2) was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #2's current FL2 dated 10/04/15 revealed diagnoses included schizophrenia. Review of Resident #2's Resident Register revealed an admission date of 09/24/16. Review of Resident #2's record revealed no documentation of any TB skin test prior to admission to the facility. Interview with the Administrator on 11/08/16 at	C 202	About resident #2 respect to her (TB) test, the resident moved in the facility with one TB test result from Davidson Behavioral Health Hospital and the facility Administrator took her to Mecklenburg County hospital to take additional TB test one have on the Policy, she face with that problem. But the Nurse told me that she need to take medicine. There was no major Concern. Found	

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C 202	Continued From page 4 11:00 am revealed: -He remembered seeing a TB skin test for Resident #2 upon admission to the facility. -He did not know why the documentation was not in Resident #2's record. -He was aware residents were required to have a two-step TB skin test upon admission to the facility. The facility provided a Plan of Protection on 11/08/16 as follows: -The facility staff will make sure all required information is present in resident records before a new resident is accepted into the facility. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 24, 2016	C 202	The resident #2 TB test result from Davidson Behavioral Health hospital was in her file. The facility recd her first TB test result and informatic was were documented in her record Book. The facility staff will make sure that all information or clients docum be placed in their record book.	12/15/16
C 316	10A NCAC 13G .1002(b) Medication Orders 10A NCAC 13G .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have orders filed in resident records for medications administered for 3 of 3 residents sampled (Resident #1, #2 and #3) for medication administration. The findings are: A. Review of Resident #1's current FL2 dated 12/14/15 revealed diagnoses included schizophrenia.	C 316	This rule was not met because of ~~to~~ how the pharmacy was handle the medicatin. ~~But discussin~~ But discussin went on between the facility Administratin and the pharmacy staffs that the way of handle medicatin should be changed. For now ~~we~~ on improvement	

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C 316	Continued From page 5 Review of Resident #1's Resident Register revealed an admission date of 07/09/16. Review of Resident #1's October and November 2016 Medication Administration Record (MAR) revealed documented administration of the following: -Atorvastatin 20 mg (used to lower cholesterol) at bedtime. -Cymbalta HCL 60mg (used to treat major depressive disorders) every day. -Levothyroxine 88 mcg (used to treat thyroid hormone deficiency) every day. -Loratadine 10mg (used to treat allergies) at bedtime. -Lyrica 50 mg (used to treat pain) twice daily. -Risperidone 3 mg (used to treat mental health disorders) at bedtime. -Trazodone 50 mg (used to treat mental health disorders) as needed. -Vitamin E 400 IU (used to treat Vitamin E deficiency) 2 every day. -Omeprazole DR 20 mg (used to treat gastrointestinal disorders) every day before breakfast. -Naproxen 500 mg (used to treat pain and fever) as needed. Review of Resident #1's record revealed no medication orders for any of the medications listed on the October or November 2016 MARs. Interview on 11/08/16 at 3:00 pm with the Administrator revealed: -Resident #1 had previously lived at the facility and moved out. -Resident #1 originally moved in 11-27-15 and moved out 3-15-16. -Resident #1 moved back to the facility on 07/09/16.	C 316	will take place at the facility. This issue happened because her doctor said that her FL2 form was still useful not yet 1 year. The resident #1 will have a new FL2 form to correct the mistake and it will not happen again - Any resident(s) move out for any time and return back,	12/30

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C 316	Continued From page 6 -The Administrator had spoken with Resident #1's physician and was advised that Resident #1 did not need a new FL2 because the FL2 was not yet a year old. -The Administrator did not realize Resident #1 needed a new FL2 since the readmission of 07/09/16. -He did not have the physician's orders for atorvastatin 20 mg at bedtime, cymbalta HCL 60mg every day, levothyroxine 88 mcg every day, loratadine 10mg at bedtime, lyrica 50 mg twice daily, risperidone 3 mg at bedtime, trazadone 50 mg as needed, vitamin E 400 IU 2 every day, omeprazole DR 20 mg every day before breakfast, and naproxen 500 mg as needed. Observation on 11/08/16 at 2:30 pm revealed medications on hand included atorvastatin 20 mg, levothyroxine 88 mcg, loratadine 10mg, lyrica 50 mg, risperidone 3 mg, trazodone 50 mg, vitamin E 400 IU, omeprazole DR 20 mg, and naproxen 500 mg. Interview with Resident #1 on 11/08/16 at 10:00 am revealed Resident #1 depended on the facility to provide medications as ordered by the physician. B. Review of Resident #2's current FL2 dated 10/04/16 revealed: -Diagnoses included schizophrenia. -An order for divalproex Sodium 500 mg (used to treat epilepsy and mental health disorders) twice daily. -An order for acetaminophen 325 mg (used to treat pain and fever) as needed. -An order for pantoprazole sodium 40 mg (used to treat gastrointestinal issues) every day. Review of Resident #2's Resident Register	C 316	new FL2 form will be required for his / her admission The facility administrator will make sure that all documents or information is correct and in placed before accepty the resident(s). while is true that all residents depends on the facility staff to pass or give their medication, it is true ~~the~~ to agree ~~with~~ with their doctor advice respect to their documentation but not medication issue. The doctor advice us check her FL2 was not a 1yr old.	

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C 316	Continued From page 7 revealed an admission date of 09/24/16. Review of Resident #2's record revealed no orders for the following: -Hydroxyzine HCL 25 mg (used to treat anxiety) four times daily as needed. -Benadryl 125 mg (used to treat allergies) at bedtime. -Cogentin 2 mg (used to reduce the side effects of antipsychotic treatment) at bedtime. -Alendronate Sodium 70 mg (used to treat osteoporosis) every week. Review of physician's order dated 10/06/16 for Resident #2 revealed: -divalproex sodium 500 mg twice a day. -cogentin 2 mg at bedtime. -benadryl 125 mg at bedtime. Review of Resident #2's record revealed no orders were located for hydroxyzine HCL four times daily as needed or meloxicam 7.5 mg as needed. Observation on 11/08/16 at 2:30 pm revealed medications on hand included divalproex sodium 500 mg, acetaminophen 325mg, pantoprazole Sodium 40 mg, hydroxyzine HCL 25 mg, benadryl 125 mg, cogentin 2 mg, and alendronate sodium 70 mg. Interview with Resident #2 on 11/08/16 at 10:00 am, during the initial facility tour, revealed Resident #2 depended on the facility to provide medications as ordered by the physician. Refer to interview with Administrator on 11/09/16 at 2:30 pm. C. Review of Resident #3's current FL2 dated	C 316	Resident # 2 ~~admission~~ admission date was and is 10/04/2016 not Sept. 24, 2016 as stated in the report. Resident # 2 benadryl 25 mg at bed time and 125 mg as stated on the document. The facility staff will make sure that all resident will be treated fairly and their medicine information / Record be in their file. All medication orders and other needed will be placed in their file. It's very true that our residents depend on the facility staff to pass	

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C 316	Continued From page 8 06/23/16 revealed diagnoses included arthritis, cocaine abuse, chronic obstructive pulmonary disease, diabetes mellitus and hyperlipidemia. . Review of Resident #3's Resident Register revealed an admission date of 07/24/15. Review of Resident #3's current FL2 dated 06/23/16 revealed the following medication orders: -Atorvastatin 10 mg (used to lower cholesterol) at bedtime. -Diclofenac topical 1% (used to treat joint pain caused by osteoarthritis) four times daily. -Glipizide 5 mg (used to control blood sugar levels) every day. -Lisinopril 5 mg (used to lower high blood pressure every day). -Albuterol 90 mcg (used to treat shortness of breath) four times daily as needed. -Alendronate 70 mg (used to treat osteoporosis) every week. -Abilify 400 mg (used to treat mental disorders) once monthly by mental health. -Vitamin D3 2000 U (used for treating weak bones) every day. -Benadryl 50 mg (used to reduce allergy symptoms) at bedtime. -Flovent HFA 44 mcg (used to prevent asthma attacks) three puffs twice daily. -Omega 3 1200 mg (used to prevent heart disease) three times daily. -Omeprazole 20 mg (used to treat symptoms of gastroesophageal reflux disease)every day. -Propranolal 20 mg (used to treat chest pain and high blood pressure) twice daily. -Trazodone 100 mg (used to treat major depressive disorder) three tablets at bedtime. -Trihexyphenenidyl 5 mg (used to treat involuntary movements due to the side effects of	C 316	Their medication allergy to the doctor's order. And the staff will Continue to do a bedtr dob. Training will be one of our key attention.	

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C 316	Continued From page 9 haloperidol) twice daily. -Vitamin E 400 mg (used to treat vitamin E deficiency) twice daily. Review of Resident #3's September, October and November 2016 MARs revealed documented administration of the following, (none of which were on the current FL2): -Haloperidol 5 mg (used to treat mental disorders) four times daily. -Nitrostat 0.4 mg (used to prevent or treat chest pain) as needed. -Multivitamin (used to provide vitamins not taken in through the diet) every day. -Pentasa 500 mg (used to treat ulcerative colitis) four times daily. -Meloxicam 7.5 mg (used to treat pain and inflammation) twice daily. -Nicotine chewing gum 2 mg (used to reduce the urge to smoke) every 2 hours as needed. Further review of Resident #3's record revealed: -A physician's order dated 05/12/16 for haloperidol 5 mg, 4 times daily. -A physician's order dated 05/10/16 for nicotine 21 mg patch, apply and remove daily. -A physician's order for nitrostat 0.4 mg, as needed for chest pain every 5 minutes, not to exceed 3 doses, dated 04/12/16. -No order for multivitamins. -A physician's order for Pentasa 500 mg, 4 times daily, dated 02/23/16. -No orders for nicotine chewing gum. Review of the orders for haloperidol 5 mg, nicotine patch 21 mg, nitrostat 0.4 mg, and pentasa 500 mg, revealed revealed each was ordered prior to the current FL2 dated 06/23/16. Interview on 11/09/16 with the Medication Aide on	C 316	All the residents order has been placed in the record books. This problem(s) happend because the doctor can sent resident strenght to the Pharmacy without informing the facility. But all rules has been placed between the facility and the Pharmacy respect to residents medication order. All medication orders has been placed in the resident record book and the staff will make sure that every Medication comes in the home order will be required and place in chiefs record book.	12/30

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C 316	Continued From page 10 duty revealed: -She administered medications based on the MAR. -She thought the MAR and the FL2 should match up: -She was not aware the MAR and FL2 did not match up. Interview on 11/09/16 at 4:00 pm with Resident #3 revealed: -He enjoyed living at the facility. -He was not aware of the medications he took daily and depended on the facility to provide the medications as ordered. Refer to interview with the Administrator on 11/09/16 at 2:30 pm. Interview on 11/09/16 at 2:30 pm with the the Administrator revealed: -Often the physicians' would fax the orders directly to the pharmacy and the facility would never receive the order. -He thought an order was complete if the entry appeared on the MAR and was entered by the pharmacy. -He was not aware that all current medication orders should be present in the resident records. -He thought that if a physician wrote an order, the order was current for one year, even if that same order was not transcribed to the new FL2.	C 316	The missed Correction has been made on Resident #3 medication because all his medication is Place in Separate Pack. At first the Pharmacy use to Put/ Combine the medication in one Pack. As an administrator, I need make sure that all information for the clients are Correct as Place in their record.	
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments	C 330		

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C 330	Continued From page 11 by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure that medications (Cymbalta-used to treat depression, divalproex sodium ER-used to treat seizure disorders, and mupirocin ointment-used to treat skin infection) were given as ordered by the prescribing physician for 2 of 3 sampled residents (Resident #1 and Resident #3). The findings are: A. Review of Resident #1's current FL2 dated 12/14/15 revealed diagnoses included schizophrenia. Review of Resident #1's Resident Register revealed an admission date of 07/09/16. Review of Resident #1's November 2016 MAR revealed: -The entry for Cymbalta 60 mg had circles in the administration boxes for the time period of November 3 - 8, 2016. -Documentation on the back of the MAR dated November 3 - 8, 2016 revealed "waiting on script". Interview on 11/08/16 at 11:00 am with the Administrator revealed: -He had gone to Resident #1's physician's office and was told to go to the pharmacy for the Cymbalta prescription. -He went to the pharmacy and was told there	C 330	All of these problems can be created if you call the doctor office to know about the clients Medicine, they will tell you to ~~go~~ ask the Pharmacy staff- when you ask them, they will say doctor never send the orders yet	

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MCCLAIN'S FAMILY CARE HOME # 1	5963 THE PLAZA ROAD CHARLOTTE, NC 28215

(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 330	Continued From page 12 were no more refills for the Cymbalta, a new prescription was needed. -He called Resident #1's physician's office and got an appointment for 11/22/16. -No Cymbalta 60 mg would be available for administration until Resident #1 saw the physician on 11/22/16. Interview on 11/08/16 at 3:00 pm with Resident #1 revealed: -The Cymbalta made Resident #1 feel "not sad". -Resident #1 took Cymbalta every morning. -Resident #1 had taken the Cymbalta every day since her admission to the facility and she was not aware of any missed doses. -Resident #1 stated she is feeling happy and not feeling sad at all. B. Review of Resident #3's current FL2 dated 06/23/16 revealed diagnoses included arthritis, cocaine abuse, chronic obstructive pulmonary disease, diverticulitis and hyperlipidemia. Review of Resident #3's record revealed a signed physician's order, dated 08/09/16 for divalproex sodium ER 250 mg twice daily. Review of Resident#3's September 2016 Medication Administration Record (MAR) revealed: -Divalproex sodium ER 250 mg twice daily was printed on the MAR. -Staff documented administration of the divalproex sodium ER 250 mg twice daily at 8 am and 8 pm. Review of Resident #3's October 2016 MAR revealed: -Divalproex sodium ER 250 mg twice daily was printed on the MAR.	C 330	The facility and Pharmacy has reach an agreement that residents medication Should be Place in a different Pack not together again, because the facility staff are not docto to know the different between medications. Staff Pass	

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C 330	Continued From page 13 -Staff documented twice a day administration of the divalproex sodium ER 250 mg twice daily at 8 am and 8 pm. Review of Resident #3's November 2016 MAR revealed: -Divalproex sodium ER 250 mg twice daily was printed on the MAR. -Staff documented administration of the divalproex sodium ER 250 mg twice daily at 8 am and 8 pm, from 11/01/16 through 11/09/16. Observation on 11/09/16 at 11:50 am of medications on hand at the facility revealed no divalproex sodium ER 250 mg available for administration. Interview with a pharmacy representative on 11/09/16 at 3:10 pm revealed: -The script was last filled on 10/05/16 with 60 tablets. -The script had expired and was sent to the physician requesting refills. -The physician had not responded to the request. Interview on 11/09/16 at 3:10 pm with the Medication Aide (MA) on duty revealed: -Resident #3's medication was packaged at the pharmacy in a multi dose package. -All of Resident #3's 8 am medications are packaged together, all of the resident's 8 pm medications are packaged together, etc. -She had not noticed that the divalproex sodium 250 mg was missing from the multi dose packs, even though the label reflected there was no divalproex sodium 250 mg in the multi dose packs. -She had continued to document the administration of the divalproex sodium 250 mg on the MAR.	C 330	Medication base on information doctor give us / facility So, the facility will match the medication pack against the MAR, to make sure the medication is in the facility or not. If, this measure put into Practice, the mistake will be Less. What the Pharmacy use to do is that, they will put all the medication together in one medication hole and send it to the facility will the medication name in the pack. If the name appear on the pack, we Consider that the Medication is there.	

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C 330	Continued From page 14 -Based on the fill date, Resident #3 had missed 10 doses of divalproex sodium 250 mg. Interview with the Administrator on 11/09/16 at 3:15 pm revealed: -He was unable to locate the divalproex sodium 250 mg for administration for Resident #3. -Resident #3's medications are packaged at the pharmacy in the multi dose packages. -He was unaware there was no divalproex sodium 250 mg available for administration to Resident #3. -He was unaware the prescription had expired and no refills remained. Interview on 11/09/16 at 4:00 pm with Resident #3 revealed he was not aware of the medications he took daily and depended on the facility to provide the medications as ordered.	C 330	The problem(s) was occured base on the information the Pharmacy gave us. But a new measure has put in place between the facility and the Pharmacy staff all Medications will have their own pack not together again and that policy is really good now. The residents/all residents depend on the facility staffs to administer their medication.	
C 415	10A NCAC 13G .1201 (a) Resident Records 10A NCAC 13G .1201 Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Facility Services and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2)	C 415	The facility will make sure that all information listed on this document be kept in the residents file.	

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C 415	Continued From page 15 of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain a current FL2 for 1 of 3 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL2 dated 12/14/15 revealed diagnoses included schizophrenia. Review of Resident #1's Resident Register revealed an admission date of 07/09/16.	C 415	The facility administrator will make sure that these rules are met when the client has been accepted to move in the ~~pro~~ home. We (staff) will make sure that residents be given fair treatment about resident FL2 form was still in a one year range and the doctor said since client is case her old FL2 should be maintained, since this is the case now on documents will be up dated.	

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C 415	Continued From page 16 Interview on 11/08/16 at 3:00 pm with the Administrator revealed: -Resident #1 had previously lived at the facility and moved out. -Resident #1 originally moved in 11-27-15, and moved out 3-15-16. -Resident #1 moved back to the facility on 07/09/16. -The Administrator had spoken with Resident #1's physician and was told that Resident #1 did not need a new FL2 because the FL2 was not yet a year old. -The Administrator did not realize Resident #1 needed a new FL2 since the readmission of 07/09/16.	C 415	Resident #1 live and moved out but her FL2 form was not a one year old. I contacted the doctor office and they told me to keep the FL2 form since it is not yet one year old. Since this is the case, from ~~not~~ now the staff will make sure all client documents will be up dated for better information.	12/30
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 were adequate related to tuberculosis test and medical examination, Medication Aides who were administering medications had completed 5, 10 or 15 hours of required Medication Aide training, staff had passed the written Medication Aide examinations and staff had verification of employment as a Medication Aide within the last 24 months, and resident rights.	C 912	The staff asked Mecklenburg Nurse to give us a document respect to the TB test results or an order form for her Medication. They told me NO. They can not send any information out of the building.	12/16

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C 912	Continued From page 17 The findings are: A. Based on record review and interview, the facility failed to assure 1 of 3 sampled residents (Resident #2) was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag 202, 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (Type B Violation)] B. Based on observations, interviews and record reviews, the facility failed to assure that all Medication Aides that were administering medications had completed the required competencies and state exam requirement before administering medications for 3 of 3 sampled staff (Staff A, B and C). [Refer to Tag 935, 131D - 4.5B(b)(1)(2)(3) Adult Care Home Medication Aides (Type B Violation)]	C 912	The administrate and staffs will make sure that the rules are med. Any new employees, Staff will make sure that he/her will have their training / Medicaid Exam before employed. Staffs who were invited their traing have completed on the 13 and 16 & Dec. 2016. All document has been placed in the record book.	
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the	C 934		

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C 934	Continued From page 18 Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled staff (Staff A) completed the state mandated infection control training annually. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 01/30/16. -Staff A worked as a Medication Aide (MA) and a Personal Care Aide (PCA). -There was no documentation of annual infection control training. Interview on 11/08/16 at 1:40 pm with Staff A revealed: -She had worked at the facility as a MA and PCA since "late January or early February". -She worked independently in the facility 5 days per week, from 2:00 pm through 9:00 am the following day. -She "might have" taken an infection control class a long time ago, she did not recall. -The Administrator was responsible for making sure all the required documents are in each employee's record. Interview on 11/08/16 at 3:10 pm with the Administrator revealed: -He thought all required information was in each employee's record. -He was not aware infection control training was required for MAs annually.	C 934	We the staff/administrator for the facility will make sure that all training be completed by the end of the year & meet the states standard. All present staff has taken the PCS training on the 16, of Dec 2016, also infection Control, 5 Hrs medical training. She had completed her infection Control class	12/16 12/16 12/16

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C935	Continued From page 19	C935	The Medical Aids training has been completed, and staff will make sure that yearly training be conducted.	12/16
C935	G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	C935		

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C935	Continued From page 20 exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure all Medication Aides who were administering medications had completed 5, 10 or 15 hours of required Medication Aide training for 2 of 3 sampled staff (Staff A and C), the facility also failed to assure 1 of 3 sampled staff (Staff B) had passed the written Medication Aide examinations and failed to assure 2 of 3 staff (Staff A and C) had verification of employment as a Medication Aide within the last 24 months. The findings are: A. Review of Staff A's employee record record revealed: -A hire date of 01-30-16. -Staff A passed the state Medication Aide (MA) exam on 07/27/05. -Staff A completed the Medication Clinical Skills Checklist on 03/24/16. -There was no documentation of employment verification as a MA within the last 24 months. -There was no no documentation of completion of the 5, 10 or 15 hour Medication Aide training. Interview with Staff A on 11/08/16 at 1:40 pm revealed: -She did not recall if she had completed the 15 hour medication class; she would check her files at home.	C935	All the staff has Completed the Medicala training as medicala Aide on the 16, 06 Dec. 2016. The other staff has taken state Exam Medicalin test and she made a Passing grade. But Staff and the administrator will Make Sure it Could not happen again.	12/16/16 12/16/16

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C935	Continued From page 21 -She had worked as a MA prior to her employment at the facility. -The Administrator was responsible for ensuring all required information is present in the employee records. -She usually worked 5 days a week at the facility, from 2 pm through 9 am the following day. -She administered all scheduled medications during her shift. Refer to interview on 11/08/16 at 3:10 pm with the Administrator. B. Review of Staff B's employee record revealed: -A hire date of 10/04/14. -There was no documentation of the state Medication Aide exam pass date. -There was no documentation of completion of the 5, 10 or 15 hour Medication Aide training. -Documentation of Staff B's completion of the Medication Clinical Skill Validation dated 05/03/14. Interview with Staff B on 11/08/16 at 2:05 pm revealed: -She had taken the state Medication Aide exam "a while back" and the results should be in her employee record. -She had been working as a MA at the facility "for about a month". -She did not recall if she had taken the state approved 15 hour MA training. -She had not been a medication aide very long. -She had been passing medications at the facility for "about a month". Review of the November Medication Administration Records (MAR) revealed: -Documentation Staff B had passed all medications for the morning medication pass on	C935	The staff in question information has been placed in her record book. Her date of employment, Medication Administration, State Exam, 5 hrs medication training and infection Control class All of these mistake was the ~~fact~~ mistake on the Administrator side but every thing will be ok. These training was met on Dec. 16, 2016 The staff was pull off from the staff list until today all these training. She took all training and pass the State Exam for medication	12/16/16 12/16 12/13/16

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C935	Continued From page 22 November 5, 2016. -Documentation Staff B had passed all medications for the morning and evening medication pass on October 9, 10, 22 and 23, 2016. Interview on 11/09/16 at 11:00 am with the Administrator revealed: -Staff B had not taken the Medication Aide exam. -Staff B only worked weekends passing medications. -Staff B will not administer medications until she successfully completed the MA exam. -The Administrator was responsible for maintaining the required information in the employee records. Refer to interview on 11/08/16 at 3:10 pm with the Administrator. C. Review of Staff C's employee record revealed: -A hire date of 01/15/14. -There was no documentation of employment verification as a MA within the last 24 months. -Staff C passed the Medication Aide state exam on 05/03/14. -Staff C completed the Medication Clinical Skills on 09/13/14. -There was no documentation of completion of the 5, 10 or 15 hour medication aide training. Attempt to interview Staff C on 11/09/16 was unsuccessful . Refer to interview on 11/08/16 at 3:10 pm with the Administrator. Interview with the Administrator on 11/08/16 at 3:10 pm revealed: -He was not aware of the state approved 15	C935	She has taken the Stke Exam on Dec. 13, 20[illegible] and make a Passy grade. She also has taken all the require training respect to RCS, infection Control, 5 Hrs medication train, First Aid/CPR. The mistake took Place in the facility and the mistake will not take Place again. The facility will now follow the ~~re~~ rules and ~~Ploicy~~ ~~of the~~ Policy. All these Policies has been met by Conducting the train and the other employee	12/9/16 12/16/16 12/13/16

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C935	Continued From page 23 hours of Medication Aide education requirement if the employment verification was not completed. -A registered nurse who was contracted to the facility has provided additional medication training, but not the state approved 15 hour training. The facility provided a Plan of Protection on 11/09/16 which included: -The facility will immediately contact a registered nurse to provide the state approved 15 hours medication training. -All future MA employees will complete the state approved 15 hour training prior to beginning work at the facility. -Staff B will not administer medications until she successfully completed the MA exam. -The Administrator will make sure all requirements were met before a MA started to work at the facility. -The Administrator will review employee records to ensure all required information is present. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 24, 2016.	C935	has Completed the Medicatin Exam and made a passing grade. The facility plan of actin on this section has Completed and all informatin has placed in their record book. All informatin and Correctin will be Completed by JAN. 15, 2017.	12/13