STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017042	A. BUILDING: _____ B. WING _____	03/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER'S FAMILY CARE HOME	10123 WADE DEAD ROAD CEDAR GROVE, NC 27231

(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 March 10, 2017.	C 000		
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 Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure the state mandatory, annual in-service training program for adult care medication sides on infection control had been completed for 2 of 2 sampled medication aides (Administrator, Staff A). The findings are: 1. Review of employee records for the Administrator revealed: - She was hired on 1/20/1995 as a personal care aide.	C 934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017042	A. BUILDING: _____ B. WING _____	03/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER'S FAMILY CARE HOME	10123 WADE DEAD ROAD CEDAR GROVE, NC 27231

(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 934	Continued From page 1 - She started working as a medication aide in 2006. - There was a Certificate of Completion for the state mandated infection control course dated 11/10/ 2014 signed by a registered nurse. - There was no Certificate of Completion for the state mandated infection control course for 2015 or 2016. Refer to interview with the Administrator on 3/10/17 at 4:45 pm. 2. Review of employee records for Staff A revealed: - He was hired on 6/16/1993 and started working as a medication aide in 2001. - There was a Certificate of Completion for the state mandated infection control course dated 8/06/2014 signed by a registered nurse. - There was no Certificate of Completion for the state mandated infection control course for 2015 or 2016. Staff A was not available for interview. Refer to interview with the Administrator on 3/10/17 at 4:45 pm. _____ Interview on 3/10/17 at 4:45 pm with the Administrator revealed: - She and Staff A did not have a current state mandated infection control training certificate in their employee records. - She understood the infection control training was required yearly, and was responsible for staff and herself having the training. - She would contact a nurse trainer and schedule the infection control training as soon as possible for herself and Staff A.	C 934		