

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL060123	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2019
NAME OF PROVIDER OR SUPPLIER MCCLAIN'S FAMILY CARE HOME # 1		STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey and a follow up survey on October 8, 2019 with a telephone exit on October 9, 2019.	C 000	RECEIVED JAN 17 2020 ADULT CARE LICENSURE SECTION RALEIGH <i>The rule was not met, and I take the responsibility. The Management team of said family care home will put a team together to make sure that all future staff documents be met before employment and I will be held that committed.</i> <i>We will check or be checks our staff record every two weeks to make sure that all information is correct.</i>	
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 1 of 3 sampled staff (Staff B) had no substantiated findings listed on the Health Care Personnel Registry (HCPR) prior to employment. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 06/13/19. -Staff B's job title was family care provider. -There were no job duties outlined for the position of family care provider. -There was no documentation a HCPR check had been completed prior to hire for Staff B. Interview with Staff B on 10/09/19 at 12:40pm revealed: -She had been employed with the facility since 06/13/19.	C 145		

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

TITLE

(X6) DATE

STATE FORM

6899

0M9C11

If continuation sheet 1 of 47

Reviewed and Acknowledged

Administrator

Karen M. Polce

01/13/20

02/03/20

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C 145	Continued From page 1 -She administered medications, provided personal care if needed, cleaned the resident's room, made beds and cooked the meals. -She did not know what the HCPR check was, or if the facility completed the HCPR check prior to her employment. Observation on 10/08/19 between 9:00am and 2:00pm revealed: -Staff B was the only staff on duty. -Staff B administered medications at noontime. -She prepared and served the lunch meal to the residents. Interview with the Administrator on 10/08/19 at 2:45pm revealed: -He had been the Administrator since 2016. -Staff B was hired as a family care provider. -She was the sole staff person from 9:00am-9:00pm, Monday through Friday. -Staff B administered medications to the residents, provided personal care when needed, light housekeeping and prepared meals. -He was responsible for checking the HCPR for new employees. -He did not know Staff B did not have a HCPR check prior to employment, or since being employed. -He contacted his office and the staff were not able to provide a copy of the HCPR check. -He was having trouble with his fax machine and email. -Documentation of an HCPR check for Staff B was not provided prior to survey exit.	C 145	The documents was at my office but she forgot the name of the meaning of HCPR. Not we will have an educational class at the facility on monthly to make sure that staff know the meaning of these words. The team will be headed by me. The facility staffing issue will be look at soon because management pay their staff base on the Personal Care fund receive from North State and is very short. For an example the state pays \$42.95 per 24 hrs per a client. Some of this problem for staffing is above our control. But we at McClain's family care home will solve the problems to have shift changes. To solve this problem(s) the management will put team together to review all employee information every 2 weeks to make sure that employee information on file.	11/13/19	
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications	C 147			

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C 147	Continued From page 2 (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 sampled staff, (Staff A), had a statewide criminal background check completed upon hire. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 10/10/14. -Her job title was family care provider. -There was documented a completed criminal background check of the county dated 06/13/19. -There was no documentation of a statewide criminal background check. Interview with the Administrator on 10/08/19 at 5:12pm revealed: -Staff A was responsible for medication administration, attending to the personal care needs and preparation of meals for the residents. -The Administrator was responsible for assuring staff had a criminal background check completed. -He had Staff A complete a county wide criminal background check upon hire. -Staff A moved to North Carolina in 2013 and had not lived anywhere else in the United States. -He did not know a statewide criminal background check was needed for Staff A. Attempted telephone interview with Staff A on 10/08/19 at 3:10pm was unsuccessful.	C 147	The management of Family care home sure that all employees meet their criminal background check before employment. This staff was done 2016 and her check was done with the County, not with the State. The staff will put a team together to be known as reviewing team and it will be headed by the director of said facility. Base my understanding was she has not live in America, so her check will be in her County where she live. But how we will change the way we do things at the Mcclain family care Home. We will conduct all checks before employee staff. As I said, we do not hire lot of staff because the fund we receiving from the state is very small, but we will apply new idea to do it different way. we are looking at things now. All back ground check will be conducted before an employment. Staff A. Criminal background check list has been send forward to conduct the Staff A. This will not happen again.	

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C 171	Continued From page 3	C 171		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 staff, (Staff A, B and C), who were non-licensed, had been competency validated for licensed health professional support (LHPS) tasks including completion of fingerstick blood sugars checks, administration of subcutaneous insulin injections and assisting with the applying and removing of compression stockings. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired on 06/13/19. -Staff B's job title was family care provider. -There were no job duties outlined for the position of family care provider. -There was no documentation Staff B had been validated for medication clinical skills competency. -There was no licensed health professional support (LHPS) competency validation checklist	C 171 C 171 Base on documents on file for all staff, we were trained by the nurse but forgot to put out the form L HPS but the name was new to the system Now on the system will be we look at in a new staff all for staff employment documents will be completed before including the L HPS and the Administrator okay the for before employment. As state As mention before, we was put a team together to handle all employees file view every 2 weeks to make sure all information is completed Staff B job duties document was place in another file; this mistake was done by us. As I said the team will be headed by the Administrator to view all staff documents for correction every 2 weeks.		

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C 171	Continued From page 4 for Staff B. Interview with Staff B on 10/09/19 at 12:40pm revealed: -She had been employed with the facility since 06/13/19. -She administered medications, provided personal care if needed, cleaned the resident's room, made beds and cooked the meals. -A nurse or pharmacist had not observed or checked her off on performing LHPS tasks for the residents. Refer to the interview with the Registered Nurse (RN) contracted to provide training and competency evaluation for the staff on 10/08/19 at 4:10pm. Refer to the interviews with the Administrator on 10/08/19 at 5:12pm. 2. Review of Staff C's (Administrator) personnel record revealed: -Staff C was the Administrator of the facility. -There was documentation of a medication skills competency validation dated 05/03/14. -There was no licensed health professional support (LHPS) competency validation for Staff C. Refer to the interview with the Registered Nurse (RN) contracted to provide training and competency evaluation for the staff on 10/08/19 at 4:10pm. Refer to the interview with the Administrator on 10/08/19 at 5:12pm. 3. Review of Staff A's personnel record revealed: -Staff A was hired on 10/10/14.	C 171	Yes, the LHPS tasks was performed or training was conducted by our Nurse but the LHPS form was not documented and the mistake was made by us. But from now on we will make sure that all documents including LHPS be completed before employment. The training evaluation for all staff is/will be completed by at all times before staff employment be carry on at the facility. All Staff LHPS Competency will be update to be placed in their file. From now all staff information will be view every 2 weeks to make sure that every thing is correct. The staff information will be review by the Administrator "Patrick McClain".	

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C 171	Continued From page 5 -Her job title was a family care provider. -There were no job duties outlined for the position of family care provider. -There was no documentation Staff A had been validated for medication clinical skills competency. -There was no licensed health professional support (LHPS) competency validation for Staff A. Attempted telephone with Staff A on 10/08/19 at 3:10pm was unsuccessful. Refer to the interview with the Registered Nurse (RN) contracted to provide training and competency evaluation for the staff on 10/08/19 at 4:10pm. Refer to the interview with the Administrator on 10/08/19 at 5:12pm. Interview with the Registered Nurse (RN) contracted to provide training and competency evaluation for the staff on 10/08/19 at 4:10pm revealed: -He had not provided any training to the staff at the facility since June of 2019. -He did not keep a record of his training of the staff. -He left documentation of staff training with the Administrator to be included in the employee records. Interview with Administrator on 10/08/19 at 5:12pm revealed: -He was responsible for assuring staff had been LHPS competency validated. -He used a checklist for staff in order to ensure all required trainings had been done. -He could not recall if the staff had completed the LHPS competency validation.	C 171	The job duties for all staff for the Family Care home will be placed in all our staff file. These information can be in our record but people go there to check our record, information can be placed some where else. As I stated, All staff information will be checked every 2 weeks for proper documentation. This mistake will not happen again. Every correction will be completed. The Nurse is now in the facility. He conducted the training but, I never give him the form to file it out for each staff. He has been contacted to complete each forms with the facility. From now, all staff information will be completed by the Nurse and the Administrator be employment. All staff documents will be review every 2 weeks to make sure that information is correct.	

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C 171	Continued From page 6 -He could not provide any documentation the staff had completed the LHPS competency validation. -He could not provide the checklist he used for staff training. -The supervisors in charge (SIC) administered insulin through injections, checked fingerstick blood sugar, and assisted with compression stockings.	C 171	<i>This will not happen again, a team will be put together to review all staff information & every 2 wks on Friday. And the team will be headed by the administrator and Co-chair by the RN.</i>	
C 174	10A NCAC 13G .0505(1)(2) Training On Care Of Diabetic Residents 10A NCAC 13G .0505 Training On Care Of Diabetic Residents A family care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; appropriate administration times; and (g) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the	C 174	<i>The facility staff will conduct diabetic training when they are hired by the within the first two weeks. The new action will be that all staff will take a diabetic training and it will not happen again. From now on, staff will be diabetic training with in two weeks upon hiring. Staff documents will be reviewed every 2 wks. The Nurse will provide the diabetic training</i>	

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C 174	Continued From page 7 facility failed to ensure 2 of 3 sampled staff, (Staff A and B), had completed training on the care of the diabetic resident prior to the administration of insulin. The findings are: 1. Review of Staff A's personnel record revealed: -She was hired on 10/10/14. -Her job title was family care provider. -There was documentation the 15 hour medication training was completed on 05/03/17. -There was documentation the medication Clinical skills was completed on 05/03/14. -There was no documentation of completion of training on the care of a diabetic resident. Review of Resident #2's October 2019 medication administration record (MAR) revealed: -Staff A documented administering Lantus insulin at 8:00pm on 10/01/19 through 10/07/19. -Staff A documented administering Lispro insulin at 8:00am on 10/06/19 and 10/07/19; at 12:00pm on 10/05/19 and 10/06/19, and at 6:00pm on 10/05/19-10/07/19. Attempted telephone interview with Staff A on 10/08/19 at 3:10pm was unsuccessful Refer to the interview with the Registered Nurse (RN) contracted to provide training and competency evaluation for the staff on 10/08/19 at 4:10pm. Refer to the interview with the Administrator on 10/08/19 at 5:10 pm. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 06/13/19. -Staff B's job title was family care provider.	C 174	Training was conducted by the Nurse the mistake part is the proper documentation was not done. The action which the facility staff will take now is that before staff start work all training will be conducted and documents signed and place in their file. These trainings will be conducted for safety of clients living and taking these medications. The Management team will put into practice for view all staff info on two weeks basis.	

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C 174	Continued From page 8 -There was documentation the 15 hour medication training was completed on 06/13/19. -There was no documentation the Medication Clinical Skills was completed. -There was no documentation of completion of training on the care of a diabetic resident. Review of a Resident #2's October 2019 medication administration record (MAR) revealed: -Staff B documented as administering Lispro insulin at 8:00am from 10/01/19 through 10/05/19. -Staff B documented as administering Lispro insulin at 12:00pm and 6:00pm from 10/01/19 through 10/04/19. Interview with Staff B on 10/09/19 at 12:45pm revealed: -She worked from 9:00am-9:00pm Monday through Friday. -She administered medications to the residents during her shift. -There was one resident who was prescribed insulin by injection. -She administered the insulin injections to the resident when she worked. -She had received some information on how to draw up insulin from the vial, how to inject the insulin and how to dispose of the syringe. when she completed the Infection Control training on 06/13/19. -She did not remember any additional training, or being required to do a return demonstration, in preparing the insulin or injecting the insulin. Refer to the interview with the Registered Nurse (RN) contracted to provide training and competency evaluation for the staff on 10/08/19 at 4:10pm.	C 174	The Nurse was called to make all documentation for all clients and documentation was completed. Our goal now is, all training for staff will be completed before hiring or starting work. As been said, all staff will take training respect to client medication before starting work and continuing education will be carryout within in system, so that staff information is well placed in their file. These measure all be headed by the administrator and co-Chair by the nurse. Management of the facility will make sure the all trainings are taken care of. The continuing education will take place every three months and the current staff training was on	11/11/19

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C 174	Continued From page 9 Refer to the interview with the Administrator on 10/08/19 at 5:10pm. Interview with the Registered Nurse (RN) contracted to provide training and competency evaluation for the staff on 10/08/19 at 4:10pm revealed: -He had not provided any training to the staff at the facility since June of 2019. -He did not keep a record of his training of the staff. -He had provided Infection Control training to the staff in the past. -He did not remember the dates of training. -He was not sure of other training he may have provided. -He left documentation of staff training with the Administrator to be included in the employee files. Interview with the Administrator on 10/8/19 at 5:12pm revealed: -He was responsible for assuring staff had completed diabetic training. -He used a check list for staff in order to ensure all trainings were done. -He was aware diabetic training had not been completed by the staff. -He had just admitted a resident in August 2019 who was the only diabetic in the facility.	C 174	The Nurse can not keep documents with him, all training information be kept in the staff file. Diabetic training is not clear, that was a mistake on our side. From now on, the complete will make sure that all training is complete before hiring staff or starting work. And the 3 men team will make sure that all documents be placed in staff file.	11/19/19
C 176	10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation Each family care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking	C 176		

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C 176	Continued From page 10 management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. If the only staff person on site has been deemed physically incapable of performing these procedures by a licensed physician, that person is exempt from the training. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure at least one staff person was on the premises at all times who had completed training in cardio-pulmonary resuscitation (CPR) and choking management course within the last 24 months for 2 of 3 sampled staff (Staff A and C). The findings are: - Review of Staff A's personnel record revealed: -She was hired on 10/10/14. -Her job title was family care provider. -There was documentation of successful completion of a CPR and Choking Management course on 09/01/16 with a recommended renewal date of 09/01/18. -There was no documentation Staff A had completed an additional CPR and Choking Management course since 09/01/18. Interview with the Administrator on 10/09/19 at 3:30pm revealed: -He did not know Staff A's CPR certification had	C 176	The facility always train the staff for first Aid, and CPR every two years but that was a mistake on our side. But we do not want it not to do the training. We have put a team together to make sure that all training is complete and place in the file. Type of mistake will be reduce in future. All employees file will be review or check every 2 weeks to make sure that all information is in place. All CPR and first Aid course has been place in their file and completed. Any staff does not have the training will be taken from the staff list until she or he produce the training document.	01/19/20

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C 176	Continued From page 11 expired. -Staff A provided care of the residents from 9:00pm on Friday through 9:00am on Monday every week, and as needed during the week. -There were no additional staff in the building with Staff A during those hours. -He was responsible for assuring the staff had current CPR certification on every shift. -He had not audited the personnel records for staff qualifications recently. Attempted telephone interview with Staff A on 10/08/19 at 3:10pm was unsuccessful. 2. Review of Staff C's personnel record revealed: -Staff C was the Administrator of the facility. -Staff C was employed as of 04/30/2011. -There was documentation of successful completion of a CPR and Choking Management course on 09/01/16 with a recommended renewal date of 09/01/18. -There was no documentation Staff C had completed an additional CPR and Choking Management course. Interview with Staff C (Administrator) on 10/09/19 at 3:30pm revealed: -He had not taken a CPR course since 09/01/16. -He did not know his CPR certification had expired. -He provided care of the residents from 9:00pm-9:00am when needed. -There were no additional staff in the building during those hours. -He transported the residents to appointments and to fast food restaurants as an occasional activity. -He was responsible for assuring the staff had current CPR certification on every shift.	C 176	We will make sure that all staff have their training on time. The training has completed and information is on file. Any staff who does not have the training will be taken from the staff list. A team has put together to make sure that all staff documents be reviewed every two weeks to make sure that ~~no~~ information is in place. The Administrator will head the team. It will not happen again as time go by.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL060123	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2019
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NAME OF PROVIDER OR SUPPLIER
MCCLAIN'S FAMILY CARE HOME # 1

STREET ADDRESS, CITY, STATE, ZIP CODE
**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 176	Continued From page 12 The facility failed to ensure at least one staff was on the premises at all times who had successfully completed CPR and Choking Management within the last 24 months, which placed the residents at risk in an event requiring CPR and/or choking intervention. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/08/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 23, 2019.	C 176		
C 236	10A NCAC 13G .0802 (a) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plans (a) A family care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan shall be an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 residents (Resident #3) had a developed care plan within 30 days of admission. The findings are: Review of Resident #3's current FL2 dated 09/20/19 revealed diagnoses included schizoaffective disorder and hypothyroidism	C 236	The plan of care for all residents is in their file but when different agency staff come to carry on reviewing documents, those documents can not be place in their file. That is where the mistake comes from. All residents 612 & Resident Care plan be prepared and taken to the doctor for signature. All these information be kept in the client file. As I stated, the team will make sure that all client information be review every two weeks to make sure that all documents are placed in client file.	

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C 236	Continued From page 13 Review of Resident #3's Resident Register revealed she was admitted to the facility on 02/18/19. Review of Resident #3's Record revealed she did not have a completed care plan since admission. Interview with the Administrator on 10/08/19 at 10:31am revealed: -Resident #3's care plan had been completed and placed in Resident #3's record. -He had not been able to find the completed care plan in Resident #3's record. -He had been waiting on the physician to complete another care plan for Resident #3. -He was aware Resident #3's care plan was missing. -He was aware the care plan should have been completed within 30 days of admission. Interview with the supervisor in charge (SIC) on 10/08/19 at 5:34pm revealed: -She was not familiar with care plans. -Residents would tell her if they needed help with toileting, bathing, dressing, or grooming. -She would ask resident's if they needed her assistance with personal care tasks. Interview with Resident #3 on 10/08/19 at 8:50am revealed: -She did not need help with bathing, showering, or using the bathroom, and she washed her own clothes. -She could not remember if an assessment had been completed by the facility when she had been admitted.	C 236	Resident #3 care plan was completed by staff and the doctor and it was placed in Resident #3 file. Only Resident or one of the resident care plan was missed place and was waiting for the doctor to sign. We have contact the doctor nurse to make an appointment for the resident doctor to sign a new care plan. From now, we will make sure that staff committee view all staff documents every 2 weeks to make sure that all information is in there. The committee will be headed by the Administrator.	11/20/19

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C 246	Continued From page 14	C 246	Resident #1 was taken EM the same day it was discovered and doctor provide some medication before meeting her primary doctor the following days. The fall was on staff who assist the resident for bath. The problem was solved the same day it was discovered. To prevent or solve all these problem, a 3 staff committee has set up to view all information on file and a body check system be carry out or carry on the daily basis. Staff who work with the clients body shall be check at the end of the shift if is a run on shift, staff shall check 7pm and 7am. Documentation will be in clients record book. All problems were reported to the administrator.	11/20/19
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to contact the primary care provider for 1 of 3 sampled residents, (Resident #1), who had an open area on the lower right abdominal area, causing irritation and discomfort to the resident. The findings are: Review of Resident #1's current FL2 dated 09/27/19 revealed: -Diagnoses included bipolar affective disorder, schizophrenia, osteoarthritis and leukopenia. -There was an order for Neosporin, an antibiotic ointment used to decrease the risk of infection following minor skin injuries, apply to the affected area three times a day as needed. -There was an order for Nystop powder, an antifungal powder used to treat yeast infections, apply to the affected area three times a day. Interview with the Resident #1 on 10/08/19 at 8:55am during the initial tour revealed: -Resident #1 had complained of an open area on her lower right abdominal area, near her hip bone, that she had for several weeks. -She had informed the Administrator and the staff regarding this open area last week and "maybe before then". -She did not know the cause of the open area. -She had requested a band aid for the open area	C 246		

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NAME OF PROVIDER OR SUPPLIER MCCLAIN'S FAMILY CARE HOME # 1	STREET ADDRESS, CITY, STATE, ZIP CODE 5963 THE PLAZA ROAD CHARLOTTE, NC 28215
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C 246	Continued From page 15 last week because the friction of her pant waist band irritated the area. Observation of Resident #1's open area on 10/08/19 at 9:05am revealed. -There was an open area on the lower right abdominal area near the hip bone. -The open area was about 2 inches in length and 1.5 inches in width, with depth not able to be determined. -The surrounding skin to the open area was intact and reddened. -There was no visible drainage. Interview with the Administrator on 10/08/19 at 9:10am revealed: -The family care providers informed him last week about the open area on Resident #1's lower right side. -He had not assessed the open area. -The family care providers had been applying cream to the area until the cream ran out on Friday (10/04/19). -The staff contacted Resident #1's family member on 10/04/19 and informed her the cream they had been applying to the area had run out. -The family member informed the staff there was a refill of the cream, ordered by the primary care provider, at the local pharmacy ready for pick up on Friday, 10/04/19. -The prescription went to the wrong pharmacy and was not ready for pick up until 10/07/19. -The Administrator was going to pick up the cream today (10/08/19). Interview with the family care provider on 10/08/19 at 11:10am revealed: -Resident #1 had complained of an irritation on her lower right abdomen. -Resident #1 had asked for a band aid last Friday	C 246	All staff will be proper training in the PCS, before starting his/her function within the facility as Care Provider. We will make a list for all training staff should take before employment. It will be a must that all employment training be conducted within that period of time. For the fact, a 3 men committee will be set up to view clients & staff document every 2 weeks to make sure that all needed information or documents are well placed in their file. All mistake which discove will be corrected. These problem has been solved, and will not continue again. The Nurse was the Trainer for the PCS	11/21/19

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C 246	Continued From page 16 (10/04/19) because of the irritation where her pant waist band rubbed against the sore. A second observation of Resident #1's wound area with the family care provider on 10/08/19 at 11:10am revealed the wound looked the same to the family care provider as on Friday (10/01/19) when she last observed it. Telephone interview with Resident #1's responsible family member on 10/08/19 at 9:50am revealed: -She received a call from the facility last week that Resident #1 had an open area on her lower abdomen. -This was a chronic condition with Resident #1 and was caused by a fungus. -She contacted Resident #1's primary care provider last week and requested a refill on her medications from June 2019 since the fungal infection had manifested again. -The physician sent a refill prescription for Nystop powder and Neosporin cream, apply to the area three times a day, wash the area before application of the powder and the cream. A second interview with Resident #1 on 10/08/19 at 10:30am revealed: -She thought the facility ran out of the cream she was applying to the open area last week. -The staff brought the cream and the powder to her and she applied it to the affected area. -She did not know she had to clean the area before applying the cream. -Several staff have seen the open area near her hip bone, but "they do not say anything about it." Telephone interview with Resident #1's primary provider's triage nurse on 10/08/19 at 11:15am revealed:	C 246	An immediately action was taking by carrying the resident to a Urgent Care and the same medication the facility has, is the medication was given to the resident to use. All staff will be checking resident on a daily basis before the next staff take over from the outgoing staff. A committee of staff will be set up to review staff daily note and other information in client's file. - Daily check will be carry on with resident. Body check on daily and note will be develop. - Staff will read all communication in Resident record. - All client medication list will be view by staff and note will be created. Every 2 weeks by the Administrator	11/29

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C 246	Continued From page 17 -Resident #1 was seen by the provider in June 2019 and was diagnosed with a rash, presenting on her lower right abdominal area, as fungal Intertrigo, an overgrowth of yeast that occurs between two connected layers of inflamed skin. -The provider prescribed Nystop powder three times a day and Neosporin to be applied until the area cleared. -Resident #1's family member contacted the provider on 10/07/19 and stated Resident #1 had a fungal outbreak in the same area as the June visit, and the skin was open and irritated. -The provider sent a prescription to the local pharmacy on 10/07/19 for an antibiotic ointment and Nystop powder, three times a day. -The provider did not know the "fungal rash" was an open area and causing the resident significant discomfort. -If the provider knew Resident #1 had an open area, untreated and uncovered, when the family member contacted the office for a refill cream, she would have requested an office visit before prescribing medication. -The facility had not contacted the provider to inform her the rash was an open area. Review of the discharge summary from an Urgent Care for Resident #1 on 10/08/19 revealed: -Resident #1 was brought to Urgent Care on 10/08/19 at 1:10pm. -The discharge diagnosis was documented as an open wound. -Resident #1 was referred to the Wound Clinic for treatment. -A culture was taken of the wound bed to rule out a possible infection. -Neosporin topical ointment was prescribed to the wound four times a day. -The area should be cleaned with warm water and patted dry, the wound evaluated for drainage,	C 246	As mention in my communication a Neosporin was prescribed by the Urgent care doctor and staff followed the direction given. There will be set up team to view all resident information and each client MAR will be view by the (RN) registered Nurse and also view all client record. Staff will check clients twice 24 hours a day. Staff will be change daily one staff will not be on assigned for 24 hours. Each staff will prepare client daily report. All staff daily report be placed in each resident file. The Nurse will check client MAR every 2 weeks/shift and check client daily basis. Patrick McClain Patrick McClain	

Division of Health Service Regulation

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C 246	Continued From page 18 the Neosporin applied and the dry dressing re-applied. Attempted telephone interview with the Urgent Care physician assistant (PA) who treated Resident #1 on 10/08/19 at 2:05pm and on 10/09/19 at 10:15am was unsuccessful.	C 246	The Nurse will always be informed. ~~the~~ staff on duty will call the Nurse, Supervisor and the Administrator if staff on duty find out anything about client(s). If that something serious 911 shall be called.	
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure a quarterly Licensed	C 254	This was not met because the staff from different go there or staff put the clients information in different file. The Immediate action will be, the Administrator and the Supervisor will view all clients file to put all documents in their right file. The next plan will be that the RAI will be called upon to view all clients information/ record. The Nurse will be called upon anytime. The RN will review file every 24 hrs	11/20/19

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C 254	Continued From page 19 Health Professional Support (LHPS) evaluations had been completed by a licensed health professional for 1 of 3 sampled residents, (Resident #2), with a LHPS task of fingerstick blood sugar (FSBS) checks and subcutaneous insulin injections. The findings are: Review of Resident #2's current FL2 dated 08/23/19 revealed: -Diagnoses included diabetes mellitus. -There was an order for Lantus insulin 100u/ml, a long acting insulin, inject 36 units at bedtime. -There was an order for Lispro insulin, 100u/ml, a short acting insulin, inject 12 units three times a day before meals. -There was an order for FSBS checks four times a day. Review of Resident #2's Resident Register revealed she was admitted to the facility on 08/23/19. Review of Resident #2's record revealed there was no LHPS evaluation completed. Interview with the Administrator on 10/08/19 at 5:20pm revealed: -He was responsible for assuring the residents with LHPS tasks were evaluated by the contracted Registered Nurse (RN). -He knew Resident #2 received FSBS checks and scheduled insulin daily. -He knew these were tasks covered in the LHPS evaluation. -He did not follow up with Resident #2 as a new admission as he should have. -He had not contacted the Registered Nurse (RN) to schedule an evaluation of LHPS tasks.	C 254	<i>The nurse will complete all forms for residents such as (LHPS) and ~~ex~~ evaluations had to be completed.</i> <i>All training was conducted but the nurse did not document it. But from now on, all documents will be complete and place in clients or staff file.</i> <i>Immediately action that/ which will be taken recently new client is that all record will be check by the staff who during the recently and contact the nurse to come and review the clients documents and see what next.</i> <i>Our long term action will be that the committee will review all documents in clients or employee file every 2 weeks for correction purpose.</i>		

11/26

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C 254	Continued From page 20 Interview with the Registered Nurse (RN), contracted by the facility to complete LHPS evaluations, on 10/08/19 at 4:10pm revealed he had not completed an LHPS evaluation for Resident #2. Based on observations and interviews it was determined Resident #2 was not interviewable.	C 254	The Nurse will complete clients ~~gpo~~ documents and stop. The 3 men committee is headed by the administrator.	
C 266	10A NCAC 13G .0904 (c-3) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure substitutions made on the menu were documented to indicate the foods actually served to residents. The findings are: Observation of the facility's regular diet menu on 10/08/19 at 11:20am revealed: -There was a Fall/Winter menu, Week 4, on the refrigerator door. -The lunch menu for 10/08/19 was 2 slices of turkey, 2 slices of whole wheat bread, 1/2 cup of peaches, 1 granola bar and 6-8 ounces of V8 juice. -There were no references to substitution items for the menu food choices.	C 266	Immediately action taken by the administrator was that her doctor office was contacted to request a 2 week-Nutrition Menu. And 2 weeks was fax to us until the facility prepare its Menus. The long term plan will be that the administrator will contact Nutrition dietitian be contacted to sign a contract with that agency to update our Menus or prepare a new Menus. The staff will make sure that the Menus be up to date.	11/26/19

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MCCLAIN'S FAMILY CARE HOME # 1

5963 THE PLAZA ROAD
CHARLOTTE, NC 28215

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C 266	Continued From page 21 Observation of the lunch meal service on 10/08/19 from 12:15pm to 12:40pm revealed: -During the meal preparation, the supervisor in charge (SIC) removed from the refrigerator a cheese sandwich on white bread cut in halves. -Only one resident was served lunch. -Three residents were out of the building and one resident refused to eat. -The SIC placed the cheese sandwich, a 12 ounce bottled water and a single serve fruit cup on the dining room table for Resident #2. -The mixed fruit cup was pre-packaged with no label as to the ingredients in the fruit cup. Interview with the SIC on 10/08/19 at 12:50pm revealed: -She was responsible for preparing meals for the residents during her shift. -She usually followed the menu on the refrigerator in preparing and serving meals. -If she did not have the food items for the meal listed on the menu, she would substitute with items that were available. -She did not have any turkey or V8 juice. -She did not know if there were any granola bars. -She did not know if there was any guidance for substituting food items of equal nutritional value. -She served the same meal to all the residents in the facility. -She did not know she had to document when she made substitutions to the meals. Observation on 10/08/19 at 12:15pm in the kitchen area revealed: -There were no substitution diet lists posted in the kitchen. -There was a yellow folder labeled Menu Substitute List on the kitchen counter. -The most recent entry in the folder was	C 266	Staff will follow the Menus on a daily basis. All staff will be trained on the client Menu to know which food to use or serve the clients. The facility will make sure that the menu be prepared by the registered dietitian in NC. As I mention in my communication, that a three men committee will review all clients information and food menu to make sure that the menu is up to date. About prepack lunch, all clients lunch can be pack in the night for client to take & take the next day. The resident current diet menu will be review on	12/15/19

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NAME OF PROVIDER OR SUPPLIER MCCLAIN'S FAMILY CARE HOME # 1		STREET ADDRESS, CITY, STATE, ZIP CODE 5963 THE PLAZA ROAD CHARLOTTE, NC 28215		
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C 266	Continued From page 22 handwritten and dated 04/19/19. Review of an unlabeled binder located in the kitchen on 10/08/19 at 12:20pm revealed: -There was a contract dated 11/05/10 between the facility and a registered dietician consulting firm. -The contract was for the purchase of a four week cycle menu prepared by a licensed dietician. Attempted telephone interview with the contracted dietician consulting firm on 10/08/19 at 1:40pm was unsuccessful. Interview with the Administrator on 10/08/19 at 2:00pm revealed: -He had contracted with the dietician for a four week cycle of menus on 10/15/10. -He had been using the four week cycle of menus since 11/05/10. -He did not receive any substitution lists for the menu items on the four week cycle. -He had advised the staff to substitute with items available in the facility that were similar. -He did the shopping and tried to follow the menu. -"Some residents do not like the menu items so we try to get them what they want." -He did not know the staff were not documenting in the substitution folder when making substitutions to the menu.	C 266	Immediately action taken the the administrator is that the doctor office was contacted for 2 weeks menu until our facility menu is prepre. They have dietician class there every Saturday ~~mon~~ morning with different group of people from different facilities for menu. We/ the facility staff will also established a continue education which will cover menu also. The Nurse will be teaching/continuing education that covers ~~menut~~ menus.	
C 270	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic	C 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL060123	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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 270	Continued From page 23 diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic diet menu for staff guidance for 1 of 1 sampled residents, (Resident #2), who had a physician's order for a consistent carbohydrate (CCHO) diet. The findings are: Review of Resident #2's current FL2 dated 08/23/19 revealed: -Diagnoses included diabetes mellitus (DM), hypertension, hyperlipidemia and gastro-esophageal reflux disease (GERD). -There was a diet order for a consistent carbohydrate diet (CCHO). Observation of the facility's regular diet menu revealed: -There was a Fall/Winter menu, Week 4, on the refrigerator door. -The lunch menu for 10/08/19 was 2 slices of turkey, 2 slices of whole wheat bread, 1/2 cup of peaches, 1 granola bar and 6-8 ounces of V 8 juice. -There were no therapeutic diet menus available to serve as guidance for the staff. -There was no CCHO diet menu available for staff to reference. Observation of the lunch meal service on 10/08/19 from 12:15pm to 12:40pm revealed: -The Supervisor in charge (SIC) served Resident #2 a cheese sandwich on white bread, a 12 ounce bottled water and a single serve fruit cup at the dining room table.	C 270	Immediately action the administrator's staff took was that the doctor office was contacted and menu plus diet therapeutic menu was requested for. The therapeutic diet was also requested for, and staff to attend the Saturday class. Long term action is that will be that staff will be attending therapeutic or menu class on Saturday as needed. This action will make for staff to know the difference before between client's diet or understand about menus. The facility will sign the contract with a dietician to prepare the facility menu and will be update every year. Als regular diet will be treated the same way. Staff will go under training and attend class to for staff to understand about different type of menu.	10/12/19

~~The Nurse Administrator~~
~~will be every three~~
~~months~~

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C 270	Continued From page 24 -The mixed fruit cup was pre-packaged with no label as to the sugar content of the juice in the fruit cup. Interview with the SIC on 10/08/19 at 12:50pm revealed: -She was responsible for preparing meals for the residents during her shift. -She served the same meal to all the residents in the facility. -She did not know Resident #2 was on a CCHO diet. -There was no list in the kitchen with the resident's diet orders. -She did not know if there was any guidance for preparing meals for residents on a therapeutic diet. -She only referenced the menu selection from the four week cycle menu on the refrigerator door. -She had not been directed to follow any other menu except the four week menu on the refrigerator door. Review of an unlabeled binder located in the kitchen on 10/08/19 at 12:20pm revealed: -There was a contract dated 11/05/10 between the facility and a registered dietician. -The contract was for the purchase of a four week cycle menu prepared by a licensed dietician. -There was no reference to any therapeutic menus developed by the licensed dietician and sent to the facility. Attempted telephone interview with the contracted dietician on 10/08/19 at 1:40pm was unsuccessful. Interview with the Administrator on 10/08/19 at 2:00pm revealed: -He had contracted with the dietician for a four	C 270	Staff will check the food label to know sugar content of all juice and fruit cups The facility will conduct continuing education within the facility for staff to know more about their clients and read their notes, FL2 forms from their doctor office. If the staff was reading client FL2, notes, and other important documents, staff will do right things. We will also check food stuff to make sure the correct label is on it. We the facility will contact a new dietician to contract a new person to prepare our food menu. The Nurse & other staff will conduct the continuing education/ Every three months.	01/30/20

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C 270	Continued From page 25 week cycle of menus on 10/15/10 for regular diets. -He had been using the four week cycle of menus since 11/05/10. -He did not receive any therapeutic diet menus from the dietician. -He knew Resident #2 was ordered a CCHO diet from the discharge orders from the hospital when she was admitted to the facility. -He had not contacted a dietician for substitutions to the regular menu for the CCHO diet ordered for Resident #2. Attempted telephone interview with Resident #2's primary care provider on 10/08/19 at was unsuccessful. Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.	C 270	<i>Patrick McLean - The Administrator will oversee the calendar.</i>	
C 291	10A NCAC 13G .0905 (c) Activities Program 10A NCAC 13G .0905 Activities Program (c) The activity director, as required in Rule .0404 of this Subchapter, shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities which shall be easily readable with large print, posted in a prominent location by the first day of each month, and updated when there are any changes;	C 291	<i>The Immediately action daily activity will be at that all clients will be involved in preparing the daily or their own daily activity. After, the administrator will look at it for approval. All clients will be ask to be involved in preparing the monthly activities. The monthly calendar & will be placed with the clients</i>	

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C 291	Continued From page 26 (3) involve community resources, such as recreational, volunteer, religious, aging and developmentally disabled-associated agencies, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are adequate supplies, supervision and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to prepare a monthly calendar of planned group activities for the residents to encourage participation, socialization, mental stimulation, physical exercise and creativity. The findings are: Observations during the initial tour of the facility on 10/08/19 from 8:45am-11:00am revealed: -There were 2 residents in their bedroom fully clothed laying in their beds. -There was a third resident lying in bed napping in her bedroom. -Two residents had already left the facility for a day program. -There was no October 2019 activity calendar posted in the facility.	C 291	Long term action will be that we will start visiting different organizations, churches and have a community activity with them. We will encourage all residents to participate in group activities. Staff will assist client to be involved in group activities. All residents aides, and other staff will be assign to different clients. The calendar will be placed in a file for all staff to be informed. The calendar was in the calendar file but the staff did not know. That is the reason, the administrator will start a continuing education in the system.	

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C 291	Continued From page 27 -The staff did not encourage the residents to leave their room and participate in any activity. Interview with two residents on 10/08/19 at 9:40am revealed: -There were no activities offered to the residents during the day. -Some of the residents would sit outside and smoke, but they did not smoke. -They watched television and stayed in bed in their rooms during the day, with the exception of meals. -Sometimes the Administrator would take them out to eat as a treat. -One of the residents would like some puzzles and coloring books to draw with, but had never asked the staff to provide these items. Interview with a third resident on 10/08/19 at 8:50am revealed: -There were no activities offered to the residents. -She would like to participate in activities. -She had not offered any suggestions to the staff regarding the activities she would like to have. Observation of activity items under an end table in the dining room on 10/08/19 at 4:05pm revealed there was a box of rainbow blocks to build a tower; a Connect 4 game and a game board that included chess and chinese checkers. Observation on 10/08/19 from 2:00pm-4:00pm revealed there were no organized activities conducted. Interview with the Supervisor in Charge (SIC) on 10/08/19 at 11:05 revealed: -Sometimes the residents would play with the rainbow blocks. -Any activity a resident pursued was self directed.	C 291	1. Staff will encourage the residents to involved in daily activity with to meet the rule standard. Staff will also call client for daily activity base on their schedule time. The facility has a activity time and staff should follow it. 2. Staff will work along with clients to meet their goal. The administrator will also be part of their activity. Daily recording will be done. All staff logging sheet for each client and it will be placed in their record file.	

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C 291	Continued From page 28 -She did not organize any activities when she worked. -Usually one of the residents would come out to the community room to watch television. -There was a September 2019 calendar. -The residents were generally not interested in activities, and she did not organize activities during her shift. -The Administrator took the residents out for meals during the month as an activity. Interview with the Administrator on 10/08/19 at 4:11pm revealed: -He was responsible for printing the calendar and posting it on the dining room wall. -He had not produced an activity calendar for October 2019. -The staff should be encouraging residents to be more active during the day and participate in planned activities. -The current residents were not interested in activities. -He did not do a lot of planned activities with the residents due to their lack of interest. -The activity supplies were stored under the end table in the dining room for the residents to use. -He took the residents on outings to fast food restaurants they enjoyed, once or twice a month. -He did not have a certified Activity Director.	C 291	<i>The activity calendar has been posted on activity board. All staff will be trained how to carry on daily activity with the residents. A committee will be set up and headed by the administrator to educate staff with all clients activity. If the staff have problems with the client to do activity, it will be documented and place in his/her record book.</i>	
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 by staff are in accordance with: (1) orders by a licensed prescribing practitioner	C 330	<i>Immediately action we will do in such a case, the supervisor will place a call to the (RN) Nurse to report to the facility to look at the medication for advice. All medication list will be compare with the MAR.</i>	01/30/20

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C 330	Continued From page 29 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 medications were administered as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents, (Resident #2), related to two medications used to treat high blood pressure, a fast acting insulin, a long acting insulin and a medication to treat elevated cholesterol levels. The findings are: Review of Resident #2's current FL2 dated 08/23/19 revealed: -Resident #2 was discharged from the hospital to the family care home on 08/23/19. -Diagnoses included chest pain, diabetes mellitus (DM), hyperlipidemia, and gastro-esophageal reflux disease (GERD). Review of Resident #2's Resident Register revealed an admission date of 8/23/19. a. Review of Resident #2's current FL2 dated 08/23/19 revealed there was a physician's order for Lisinopril 5mg, (a medication used to treat hypertension), one tablet to be given daily. Review of Resident's #2's September 2019 Medication Administration Record (MAR) revealed: -There was an entry for Lisinopril 5mg to be administered once daily at 8:00am. -There was documentation Lisinopril was not administered on 09/01/19 through 09/16/19 at	C 330	The immediately action will be that client FL2 form will fax to their doctor before their appointment time/date. because sometime the resident can bring the correct medication before their appointment time. New client's doctor's number will be place in the front front page of the client record book for all staff to be aware. Long term plan: IS committee will be set up in the facility to educate staff about residents medication, and how to fax client FL2 forms. If client come in the facility, his/her FL2 be fax to the doctor office be appointment time, and ~~done~~ documentation will be done. The documents will be place in client file. Every 2 weeks	11/2/19

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C 330	Continued From page 30 8:00am, and no documented reason on the MAR the Lisinopril was not administered to Resident #2. Telephone interview with a representative at the facility's contracted pharmacy on 10/09/19 at 10:25am revealed: -Resident #2's medication orders were sent from the facility on a hospital discharge FL2 dated 08/23/19 for a thirty day supply. -Thirty tablets of Lisinopril 5mg were dispensed on 08/28/19 for Resident #2. Refer to the interview with the primary care provider's office on 10/08/19 at 2:40pm. Refer to the interview with the Supervisor in Charge (SIC) on 10/08/19 at 3:16pm. Refer to the interview with the Administrator on 10/08/19 at 3:40pm. Refer to the interview with the hospital pharmacist on 10/9/19 at 11:12am. b. Review of Resident #2's current FL2 dated 08/23/19 revealed there was a physician's order for Metoprolol 25mg, (a medication used to treat hypertension), one tablet every twelve hours. Review of Resident's #2's September 2019 Medication Administration Record (MAR) revealed: -There was an entry for Metoprolol Tartrate 25mg to be administered every 12 hours, at 8:00am and 8:00pm. -There was documentation Metoprolol was not administered to Resident #2 on 09/01/19 through 09/16/19 at 8:00am and 8:00pm, and the reason documented was the medication was "out."	C 330	All Residents record will be check by the nurse on weekly and the Adm. Inistrator will also view clients medication to make sure ellet the right information is placing or recording in the MAR & for all residents. Residents files will also be check by the two men Committee Set up by the Administrator of the facility.	

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C 330	Continued From page 31 Telephone interview with a representative at the facility's contracted pharmacy on 10/09/19 at 10:25am revealed: -Resident #2's medication orders were sent from the facility on a hospital discharge FL2 dated 08/23/19 for a thirty day supply. -Thirty tablets of Metoprolol were dispensed on 08/28/19 for Resident #2. Refer to the interview with the primary care provider's office on 10/08/19 at 2:40pm. Refer to the interview with the Supervisor in Charge (SIC) on 10/08/19 at 3:16pm. Refer to the interview with the Administrator on 10/08/19 at 3:40pm. Refer to the interview with the hospital pharmacist on 10/9/19 at 11:12am. c. Review of Resident #2's current FL2 dated 08/23/19 revealed there was a physician's order for Humalog 100 units/ml, (a fast-acting insulin used to treat high blood sugar), twelve units three times a day. Telephone interview with a representative of the facility's contracted pharmacy on 10/09/19 at 10:25am revealed: -Resident #2's medication orders were sent from the facility on a hospital discharge FL2 dated 08/23/19 for a thirty day supply. -The pharmacy dispensed one box of Humalog (twenty-seven day supply) on 08/28/19 for Resident #2. Review of Resident's #2's September 2019 Medication Administration Record (MAR) from	C 330	<i>The facility staff will make sure a good communication be between the two staff the facility and where the resident is coming from.</i> <i>The facility staff will make sure that the in coming resident's New resident medication is correct and one month supply be given to the resident before moving in the facility. As soon, the resident move in the facility, the resident FL2 be fax to his/her doctor before her appointment date. All residents MAR and other documents be view every 2 weeks by the Committee or the Adminis trator.</i>	

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C 330	Continued From page 32 09/01/19 through 09/30/19 revealed: -There was an entry for Humalog insulin, 12 units three times a day, to be administered at 8:00am, 12:00pm and 6:00pm. -There was documentation Humalog insulin, 12 units three times a day, was not administered to Resident #2 on 09/17/19 through 09/24/19 at 8:00am, 12:00pm and 6:00pm, and the documented reason was the medication was "out". -There was no documented reason on the MAR the Humalog insulin was not administered on 09/17/19 through 09/20/19. -There was no entry or documentation of fingerstick blood sugar checks for Resident #2. Refer to the interview with the primary care provider's office on 10/08/19 at 2:40pm. Refer to the interview with the Supervisor in Charge (SIC) on 10/08/19 at 3:16pm. Refer to the interview with the Administrator on 10/08/19 at 3:40pm. Refer to the interview with the hospital pharmacist on 10/9/19 at 11:12am. d. Review of Resident #2's current FL2 dated 08/23/19 revealed there was a physician's order for Levemir FlexTouch 100 units/ml, (a long acting insulin used to treat high blood sugar), thirty-six units daily. Telephone interview with a representative of the facility's contracted pharmacy on 10/09/19 at 10:25am revealed: -Resident #2's medication orders were sent from the facility on a hospital discharge FL2 dated 08/23/19 for a thirty day supply.	C 330	<i>All staff training will be conducted and documented by the nurse before the client move in the facility. All staff will undergo training at any time in the facility if the client medication is not giving the right way. Staff will have to go under monthly training for clients, record, medication, and or important information respect to clients.</i>	

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NAME OF PROVIDER OR SUPPLIER MCCLAIN'S FAMILY CARE HOME # 1		STREET ADDRESS, CITY, STATE, ZIP CODE 5963 THE PLAZA ROAD CHARLOTTE, NC 28215		
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C 330	Continued From page 33 -The pharmacy dispensed one box (a forty-one day supply) of Levemir, thirty-six units daily, on 08/28/19 for Resident #2. Review of Resident's #2's September 2019 Medication Administration Record (MAR) revealed: -There was an entry for Levemir FlexTouch insulin, thirty-six units, to be administered daily at 8:00pm. -There was documentation Levemir insulin, thirty-six units, was not administered to Resident #2 on 09/17/19 through 09/23/19 at 8:00pm, and the documented reason was -the medication was "out." -There was no documented reason on the MAR that Levemir insulin was not administered to Resident #2 on 09/17/19 through 09/20/19 and 09/24/19. Refer to the interview with the primary care provider's office on 10/08/19 at 2:40pm. Refer to the interview with the Supervisor in Charge (SIC) on 10/08/19 at 3:16pm. Refer to the interview with the Administrator on 10/08/19 at 3:40pm. Refer to the interview with the hospital pharmacist on 10/9/19 at 11:12am. e. Review of Resident #2's current FL2 dated 08/23/19 revealed there was a physician's order for Atorvastatin 80mg, (a medication used to treat elevated cholesterol levels in the blood,) one tablet to be given daily at bedtime. Review of Resident's #2's September 2019 Medication Administration Record (MAR)	C 330	A System will be set up by recording client Medication on a different recordy book to show when the medication came due, when it finishes, and if the medication is out document it, document when the doctor was contact, And all info main is the record book. ~~Detail~~ More information on Client's Medication will be written on the Client's Personal Record file- All Client's Medication be enter in/on the Client Personal record file which will be placed in his/her file.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL060123	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2019
NAME OF PROVIDER OR SUPPLIER MCCLAIN'S FAMILY CARE HOME # 1		STREET ADDRESS, CITY, STATE, ZIP CODE 5963 THE PLAZA ROAD CHARLOTTE, NC 28215		
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C 330	Continued From page 34 revealed: -There was an entry for Atorvastatin 80mg to be administered at 8:00pm. -There was documentation Atorvastatin was not administered to Resident #2 on 09/01/19 through 09/30/19 at 8:00pm and the documented reason was -the medication was "out." -Documentation on the back of the MAR stated the reason the Atorvastatin was not administered on 09/22/19, and 09/28/19 through 09/30/19 at 8:00pm was the medication was "out." -There was no documentation on the MAR indicating the reason Atorvastatin was not administered from 09/01/19 through 09/21/19. Telephone interview with a representative of the facility's contracted pharmacy on 10/09/19 at 10:25am revealed the pharmacy did not have a prescription to refill Atorvastatin on profile for Resident #2. Interview with a representative from Resident #2's primary care provider's office staff on 10/18/19 at 2:40pm revealed: -Resident #2 was last seen by the primary care provider on 09/06/19. -New prescriptions were sent to the facility's contracted pharmacy in 09/16/19. -The provider's office was not aware Resident #2 went without her prescribed medications Lisinopril, Metoprolol, Humalog and Levemir. -Resident #2 could have shown signs of shortness of breath and her blood pressure could have increased related to Lisinopril and Metoprolol not being administered as ordered by the provider. -If Resident #2 missed her dosage of Humalog and Levemir her blood sugars would possibly become elevated and she could be admitted to the hospital for hyperglycemia.	C 330	All client medication will be monitor by staff to make sure that all client information is being recorded the right way. Before clients enter in the facility, staff will make sure that all medications are correct and FL2 form fax to her/his doctor for any action. Refill correction on information. All staff will be inform or train with each clients enter in the facility with their medication and another information on the client. The Home staff Priscilla T. Myers	

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C 330	Continued From page 35 -The facility should have attempted clarification regarding the continued use of Atorvastatin. -The physician's office staff had not received the hospital discharge FL2 with the Atorvastatin listed as a new medication. -Resident #2 did not have an order to take blood pressure readings or fingerstick blood sugar checks on her medication profile. Interview with the supervisor in charge (SIC) on 10/08/19 at 3:16pm revealed: -The "x" on a resident's MAR indicated the medication was never administered to the resident. -She would initial the MAR to indicate a medication was administered. -She was not working at the facility the day Resident #2 was admitted. -She would tell the Administrator when a resident was out of their medication. -The Administrator was aware Resident #2 did not have her medications. Interview with the Administrator on 10/18/19 at 3:40pm revealed: -He knew Resident #2 was close to running out of her medications. -There was a delay in getting her medications. -He contacted the hospital to refill medications the resident had been discharged with. -He contacted Resident #2's provider and never received a return phone call. -He called the provider again, and Resident #2's appointment at the office was scheduled for 09/06/19. -Resident #2 went to her physician's office on 09/06/19 and received new prescriptions for her medications. -The provider did not send refill prescriptions for Resident 2's Atorvastatin to the pharmacy.	C 330	Staff will make sure that all client Meds be in the home at all times. Five days will be given for refill. The X on the MAR means that the medication never stand on that date. If the doctor give give new medication to the client, we mark X on the date new Administer. That the X stands for. The facility staff will design a better format for that purpose.	

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C 330	Continued From page 36 -Atorvastatin was not prescribed by the primary care provider. -Atorvastatin was prescribed by the hospitalist during a recent admission. -The Administrator did not send the hospital FL2 to the provider at discharge..	C 330	All FL2 forms for client will be sent to the client Primary care provider when he/she enters & Administer in the facility before the regular appointment.	
C 353	10A NCAC 13G .1006(b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure prescription medications were stored in a safe manner, maintained under locked security, except when under the immediate or direct physical supervision of staff in charge of medication administration, for 3 of 3 sampled residents (Residents #1, #2, and #3) in the facility. The findings are: Observation on 10/08/19 at 11:20am revealed: -There was a small wooden cabinet, with 2 panels, located in the common living room, secured with a lock and chain through the handles. -The right sided panel was not attached to the hinges and was not secured to the body of the cabinet by any other means.	C 353	The Immediately action stored medication in the right place. The medication which belongs refrigeration should be placed a container. All medication will be put in the proper area base on the label. Long term: All staff will be train how to handle medication in the facility. All medication labels stay refrigerate, and also the nurse will be asked too for better understanding. will be Trained by the RN Nurse and every 2 weeks	

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C 353	Continued From page 37 Observation on 10/08/19 at 12:20pm revealed: -The medication storage cabinet was unlocked and open. -The right sided panel of the cabinet was propped against the living room wall. -There were 5 plastic bins, labeled with the residents' names, containing the residents' medications. -There was no staff person in the room. Interview with Resident #1 on 10/08/19 at 3:15pm revealed: -The SIC would bring the medications to her in the bedroom. -She had observed the door to the medication cabinet open and to the side. -She did not recall how long it had been that way. -She saw the lock on the cabinet door when it was closed and assumed the medications were secured. Based on observations and interviews it was determined Resident #2 was not interviewable. Attempted interview with Resident #3 on 10/08/19 at 4:10pm was unsuccessful. Interview with the SIC on 10/08/19 at 12:50pm revealed: -The residents' medications were always kept in the unlocked cabinet. -The door of the cabinet had been broken from the hinges for "quite awhile", she could not say how long. -The lock that was affixed to the cabinet panels did not secure the cabinet, since the right hand panel was not on the hinges. -She left the right sided panel propped against the wall when she was administering	C 353	The Medication Cabinet will be locked and keys be with the staff. The handling of medication in the facility will be changed. And all staff will be educated & trained on that. The facility administrator will purchase a new cabinet for medication. The committee will view all clients activities such as client medication, documents, medication storage place, room, and others. This action will solve most of the problems in the facility. This our first time for such a correction. By 01/05/20	

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C 353	Continued From page 38 medications. -She always knew where the residents were in the room with so there were no safety concern. Observations on 10/08/19 at various times revealed: -The residents passed through the common living area from their rooms. -One resident was watching television in the common area. -Staff were not always present in the view of the common room and the medication cabinet. Interview with the Administrator on 10/08/19 at 5:30pm revealed: -He knew the panel of the medication storage cabinet was not properly secured. -He thought the lock and chain served to secure it. -He did not know the panel was completely removed from the cabinet and the lock and chain did not secure the medication storage. -He did not know how long the medication storage cabinet had not been secured. -He was confident the staff were aware of residents and their location when the cabinet was opened for a medication pass. -He had not been told there were any residents attempting to get in to the medication cabinet.	C 353	<i>Staff will be at the comm on and the Medication area. The Medication Storage area/place will be change for client safety problems. The committee will sure that all these rules be followed.</i>	
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.	C 912	<i>The immediately action is/ will be that all staff be send to Red Cross to register for the training or get some one to do the training Someone who has done the</i>	

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C 912	Continued From page 39 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations, related to staff training on cardio pulmonary resuscitation (CPR) and choking management. The findings are: A. Based on interviews and record reviews, the facility failed to assure at least one staff person was on the premises at all times who had completed a cardio-pulmonary resuscitation (CPR) and choking management course within the last 24 months for 2 of 3 sampled staff, (Staff A and C). [Refer to Tag 176 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)].	C 912	Training will be called to work until the training is done. Long term: All staff will complete their training before starting work. Also staff will be wiew to know staff re-new ab their training/ documentation. The Committee will make sure that all staff documents be re-new at all times. CPR and Choking Management course within 24 hr months will be followe to maintain safety in the facility - All courses will be trained as followed the guide lines. The infection Control Policy will be met according to the Policy. All staff will go under the training	
C 932	G.S. 131D 4.4A (b) ACH Infection Prevention Requirements 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable	C 932		01/19/20

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MCCLAIN'S FAMILY CARE HOME # 1

5963 THE PLAZA ROAD
CHARLOTTE, NC 28215

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C 932	Continued From page 40 patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines for infection prevention for 1 of 1 sampled residents, (Resident #2), when bending and re-capping a used insulin needle before disposing of the syringe. The findings are:	C 932	Staff will be replace with staff did the training and Contact Redcross for other staff to go under training until CPR. All staff will be trained with CPR. The facility staff will make sure that all employees take the training. These training will be complete every 24 months. Again, staff will be replace with staff went took the training staff not yet take the training will be send to Redcross for the training.	

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C 932	Continued From page 41 Review of the CDC's recommended guidelines for infection transmission and prevention during disposal of used needles revealed: -Used needles should not be re-capped. -Used needles were to be placed immediately in a sharps disposal container, uncapped. -There was a danger when re-capping a used needle the individual may stick themselves. -Bending or breaking a used needle could lead to accidental needle sticks. Review of Resident #2's current FL2 dated 08/23/19 revealed: -Diagnoses included diabetes. -There was an order for Humalog insulin, 12 units, to be administered three times a day before meals. Observation on 10/08/19 at 11:50am revealed: -Resident #2 was sitting in a chair at the dining room table. -She was the only resident in the room and the lunch meal had not been served. -The supervisor in charge (SIC) drew 12 units of insulin into a syringe and administered the insulin in Resident #2's right upper arm. -After removing the needle from the resident's arm, the SIC thrust the needle into the side of the dining table, causing the needle to bend in a U shape. -She then recapped the needle with her hand and disposed of it in the sharps container on a nearby shelf. -She did not sanitize her hands after administering the insulin. Interview with the SIC on 10/08/19 at 11:55am revealed: -She always disposed of the needle and syringe by bending the needle in a nearby object, capping	C 932	<i>Staff will be train how to handle these use needles</i> <i>The Immediately action is to call nurse to have trainy with the staff how to handle needle after using it. All used needle will be place in the red container not bend it like a U. Do not use you hand. All these is cause by lot of trainy with sure medication.</i> <i>But from now on, all staff will be trained properly how to handle client needle</i> <i>Staff be trained with or client's medication including needle, how to handle these used needle.</i>	

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C 932	Continued From page 42 the needle and disposing of it in the sharps container. -She was taught that procedure by the "nurse". -She thought it was the nurse who taught the infection control class. Interviews with the Administrator on 10/08/19 at 5:15pm revealed: -He did not train the SIC's in medication administration. -He did not train the SIC's to bend needles and recap as a means to dispose of needles and syringes. -He did not know if the Licensed Health Professional Support (LHPS) nurse taught the SIC's to dispose of needles in that manner. -He would contact the LHPS nurse for additional training for the staff. Attempted telephone interview with the LHPS nurse on 10/09/19 at 10:50am was unsuccessful.	C 932	<i>Training will be conducted with staff how to handle clients medications. All area need training will be done at all times. Training will complete before staff starts work or continue work. It will part of our rules and it is. All staff shall complete yearly training base on the policy of the family care home. Also, all aides training will be conducted on time. The 80 hrs training will also conducted on time. All training will be taken by the staff on time.</i>	
C937	G.S. 131D-4.3 (a) ACH Training for Personal Care Aides G.S. 131D-4.3 (a) Adult care home training for personal care aides (2) A minimum of 80 hours of training for personal care aides. The training for aides shall be comparable to State-approved Certified Nurse Aide I training. The facility may exempt from the 80-hour training requirement any personal care aides who are or have been either licensed as a health care professional or listed on the Nurse Aide Registry. (3) Monitoring and supervision of residents. (4) Oversight and quality of care as stated in G.S. 131D-4.1.	C937		

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MCCLAIN'S FAMILY CARE HOME # 1

5963 THE PLAZA ROAD
CHARLOTTE, NC 28215

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C937	Continued From page 43 (5) Adult care homes shall comply with all of the following staffing requirements: a. First shift (morning): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents (licensed capacity or resident census) plus 3.0 hours for all other residents, whichever is greater; b. Second shift (afternoon): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents plus 3.0 hours for all other residents (licensed capacity or resident census), whichever is greater; c. Third shift (evening): 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). The facility shall provide staff to meet the needs of the facility's residents. Each facility shall post in a conspicuous place information about required staffing that enables residents and their families to ascertain each day the number of direct care staff and supervisors that are required by law to be on duty for each shift for that day. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 3 sampled Staff (Staff A) had documentation of successfully completing an 80-hour personal care training program, including competency evaluation. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired on 10/10/14. -Staff A's job title was family care provider. -There were no job duties outlined for the position	C937	All these rules will look at and training how to handle the staffing problems, these will be carry on as the rule said. ~~the~~ The facility will train all staff about these rules. Census will be called in on a daily base to know how much clients and staff on shift. The Administrator will make training be possible on time according to the state rule/policy. The 80 hrs PCS training will be conducted on time, be documented on time. All staff record will be up to date. Staff job duty will be outline for their position in the facility.	

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C937	Continued From page 44 of family care provider. -There was no documentation Staff A completed an 80-hour personal care training program and competency evaluation. Interview with the Administrator on 10/08/19 at 2:45pm revealed: -He was responsible for assuring the staff received the training required to provide proper care to the residents. -He did not know the staff were required to complete a 80 hour personal care training program. -He had not provided for the training of the staff in the personal care program. -Staff A functioned as the supervisor in charge (SIC), working every weekend alone, from Friday at 9:00pm through Monday at 9:00am. -Staff A provided personal care, if needed, for the residents Interview with the Registered Nurse (RN) contracted to provide training and competency evaluation for the staff on 10/08/19 at 4:10pm revealed: -He had not provided any training to the staff at the facility since June of 2019. -He did not keep records of staff training. -He left any training certification with the Administrator to be filed in the personnel record of the staff. Attempted telephone interview with Staff A on 10/08/19 at 3:10pm was unsuccessful.	C937	As it was measured in my interview, that I was responsible because the staff did not conduct the training and the staff had work. But staff A being with the body for past some years and differed staff from different Agency been going there to check, and did not see that mistake for correction. From now the Administrator will put a working team together to review all staff documents every 2 weeks on one time a month to make sure that everything is together. The Administrator will head that working team. This will be completed by Dec 20, 2019. Now things are almost completed.	DEC 20, 19
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for	C992		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL060123	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2019
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NAME OF PROVIDER OR SUPPLIER MCCLAIN'S FAMILY CARE HOME # 1	STREET ADDRESS, CITY, STATE, ZIP CODE 5963 THE PLAZA ROAD CHARLOTTE, NC 28215
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(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
C992	Continued From page 45 the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure an examination and	C992	<i>Immediately action is to send as staff to do the examination and screening for controlled substance. The screening will be conducted immediately and documented.</i> <i>Long term: All staff before employment will go under the screening. The information will part of their record. The committee will make sure that all information is kept in their file.</i>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL060123	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2019
NAME OF PROVIDER OR SUPPLIER MCCLAIN'S FAMILY CARE HOME # 1		STREET ADDRESS, CITY, STATE, ZIP CODE 5963 THE PLAZA ROAD CHARLOTTE, NC 28215		
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C992	Continued From page 46 screening for controlled substances was completed for 1 of 3 sampled staff (Staff A), prior to hire. The findings are: Review of Staff A's personnel record revealed: -She was hired on 10/10/14. -Her job title was family care provider. -There was no documentation that a controlled substance screening had been completed for Staff A. Interview with two residents on 10/08/19 at 8:55am revealed Staff A administered medications to the residents, cooked meals and provided assistance to the residents if needed. Attempted telephone interview with Staff A on 10/08/19 at 3:10pm was unsuccessful Interview with the Administrator on 10/08/19 at 5:10pm revealed: -Staff A worked every weekend from 9:00pm Friday evening through Monday morning at 9:00am, and weekday evenings as needed. -Staff A administered medications, provided personal care as needed and prepared meals for the residents. -He knew the staff were required to have a controlled substance screening before starting to work in the facility. -He thought Staff A had completed the controlled substance screening. -He was responsible for ensuring personnel records were current and contained all the necessary documentation for employment. -He had not audited the personnel records recently.	C992	The problem(s) for the staff A was cause by the administrative because information/documents were not check by the administrative. Also, staff A being in the facility for some years, and nobody never bring it to our attention. Staff from different Agency came to check our documents but nobody never mention to us. From now on the Administrator will make sure that information for correction is carry out and training be conducted before work begins. All training including controlled substance before starting work in the facility. This training will be completed Dec. 12, 2019. Nurse has contact for the training.	12/12/19

