STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 000}	Initial Comments The Adult Care Licensure Section and the Mecklenburg Couty Department of Social Services conducted a follow-up survey on 02/12/20.	{C 000}		
{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 facility failed to ensure 3 of 3 sampled staff, (Staff A, B, and C), had completed training on the care of the diabetic resident prior to the administration of insulin.	{C 174}		

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{C 174}	Continued From page 1 The findings are: 1.Review of Staff A's (Administrator) record revealed: -He had been the Administrator since 2016. -There was documentation of a medication skills competency validation dated 05/03/14. -There was no documentation of completion of training on the care of diabetic residents. Review of a resident's February 2020 Medication Administration Record (MAR) revealed Staff A documented administering Levemir insulin at 8:00aam on 02/09/20. Refer to interview with the Administrator on 02/12/20 at 3:52pm. 2. Review of Staff B's personnel record revealed: -She was hired on 10/10/14. -Her job title was care provider. -Staff B's job description included medication administration. -There was no documentation of completion of training on the care of a diabetic resident. Review of a resident's February 2020 Medication Administration Record (MAR) revealed Staff B documented administering Levemir insulin at 8:00am on 02/08/20. Attempted telephone interview with Staff B on 02/12/20 at 3:00pm was unsuccessful. Refer to the interview with the Administrator on 02/12/20 at 3:52pm. 3. Review of Staff C's personnel record revealed: -Staff C was hired on 01/29/16.	{C 174}		

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{C 174}	Continued From page 2 -Staff C's job title was care provider. -Staff C's job description included medication administration. -There was no documentation of completion of training on the care of a diabetic resident. Review of a resident's February 2020 MAR revealed Staff C documented as administering Levemir insulin at 8:00am from 02/06/20-02/07/20 and 02/10/20-02/11/20. Interview with Staff C on 10/09/19 at 12:45pm revealed: -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 during her medication clinical skills validation. -She did not remember any additional training in preparing the insulin or injecting the insulin. Refer to the interview with the Administrator on 02/12/20 at 3:52pm. _____ Interview with the Administrator on 02/12/20 at 3:52pm revealed: -He was responsible for assuring staff had completed diabetic training. -He was aware diabetic training had not been completed for the staff. -He was working to get a Registered Nurse (RN) to come and complete the competency validation. -He spoke with a RN that he scheduled to come "this weekend".	{C 174}		

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{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 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 low carbohydrate diabetic diet. The findings are: Review of Resident #2's current FL2 dated 02/06/20 revealed: -Diagnoses included schizoaffective disorder and diabetes. -There was a diet order for a low carbohydrate diabetic diet. Observation of the facility's regular diet menu revealed: -There was a Fall/Winter menu on the refrigerator door. -The lunch menu included 1 tablespoon peanut butter, 1 teaspoon of jelly, 2 slices of whole wheat bread, 1 banana, ½ cup chocolate pudding, 6-8 ounces of juice. -There were no therapeutic diet menus available to serve as guidance for the staff. -There was no low carbohydrate diabetic diet menu available for staff to reference.	{C 270}		

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{C 270}	Continued From page 4 Observation of the lunch meal service on 02/12/20 from 11:00am to 11:45am revealed: -Resident #2 retrieved her bagged lunch from the refrigerator. -Resident #2 consumed a bologna and cheese sandwich on white bread, a 12-ounce bottled water, one pack of vanilla sugar wafers, and a single serve fruit cup at the dining room table. -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 supervisor in charge (SIC) on 02/12/20 at 3:21pm 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 low carbohydrate diabetic 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 (regular) on the refrigerator door. -She had not been instructed to follow any other menu except the regular menu on the refrigerator. Interview with the Administrator on 02/12/20 at 3:52pm revealed: -He had contracted with the dietician for a cycle of menus on 10/15/10 for regular diets. -He had been using the cycle of menus since November 2010. -He did not receive any therapeutic diet menus from the dietician.	{C 270}		

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{C 270}	Continued From page 5 -He was working to get a new contracted dietician. -He did not realize Resident #2 was ordered a low carbohydrate diabetic diet. Attempted telephone interview with Resident #2's primary care provider on 02/12/20 at 3:09pm was unsuccessful. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable.	{C 270}		
C 281	10A NCAC 13G .0904(e)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to obtain a current diet order in writing from a physician for 1 of 3 sampled residents (Resident # 1). The findings are: Review of Resident #1's current FL2 dated 09/27/19 revealed:	C 281		

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C 281	Continued From page 6 -Diagnoses included bipolar affective disorder, osteoarthritis, obesity, and osteoporosis. -There was no diet order listed. Review of Resident #1's record revealed there was no signed physician's order with a diet listed. Observation in the facility kitchen on 02/12/20 at 8:39am revealed there was no diet list posted on the refrigerator for the guidance of food service staff. Observation of the facility's regular diet menu revealed: -There was a Fall/Winter menu on the refrigerator door. -The lunch menu included 1 tablespoon peanut butter, 1 teaspoon of jelly, 2 slices of whole wheat bread, 1 banana, ½ cup chocolate pudding, 6-8 ounces of juice. Observation of Resident #1 at 10:00am revealed: -Resident #1 left the facility for a day program and took a bagged lunch from the refrigerator with her. -Resident #1's bagged lunch included a bologna and cheese sandwich, a fruit cup, vanilla sugar wafers, and a 12-ounce bottle of water. Interview with the supervisor in charge (SIC) on 02/12/20 at 3:21pm revealed: -She had not realized there was not a diet order in Resident #1's record. -She assumed Resident #1's diet was regular because she did not have a specific diet order. -The SICs and the Administrator were all responsible for obtaining diet orders from the physician. -She had not reached out to the facility to obtain a diet order for Resident #1, "I guess it was an	C 281		

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C 281	Continued From page 7 oversight". Interview with a nurse for Resident #1's primary care provider (PCP) on 02/12/20 at 2:30pm revealed: -There were no dietary restrictions in Resident #1's physician notes. -The facility had not contacted the physician regarding a diet order for Resident #1. -The physician's dietary order would need to be discussed with the physician and the order would be faxed to the facility. Interview with Resident #1 on 02/12/20 at 3:40pm revealed: -She was not on any diet restrictions. -During meals she received the same food as everyone else in the facility. -She knew she was supposed to monitor her portions, but she was unsure of how she was supposed to monitor her intake. Interview with the Administrator on 02/12/20 at 3:52pm revealed: -He and the SICs were responsible for obtaining a diet for each resident upon admission. -He expected every resident to have a diet order in their record. -He did not realize Resident #1 did not have a diet order in the record. -He had not reached out to the PCP to get a diet order, "it was an oversight".	C 281		
{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:	{C 291}		

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{C 291}	Continued From page 8 (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; (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 encourage socialization, mental simulation, physical exercise and creativity by providing activities for 3 of 3 residents. The findings are:	{C 291}		

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{C 291}	Continued From page 9 Observations initial tour of the facility on 02/12/20 from 8:30am-12:00pm revealed: -There was one resident in the living room watching television. -There was one resident sitting on the back porch unoccupied. -Two residents had already left the facility for a day program. -One additional resident left the facility at 10:00am to attend a day program. -The staff did not encourage the residents to participate in any activity. Observation of the February 2020 activity calendar revealed: -The facility had one activity listed each day throughout the month. -On Sundays, Church Service was scheduled with no times listed. -On Saturdays, a community walk was scheduled from 3 pm-5pm. -Monday - Friday had one activity per day for two hours including afternoon activities of jumbling game and chess game from 3:00pm-5:00pm, and pizza night, store outing, and Connect 4 from 5:00pm-7:00pm. Observation of activity items under an end table in the dining room on 02/12/0 at 10:00am revealed there was a box of building blocks; a Connect 4 game and a game board that included chess and checkers. Observation on 02/12/20 from 8:30am-4:00pm revealed there were no organized activities conducted. Interview with a resident on 02/12/20 at 8:39am revealed:	{C 291}		

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{C 291}	Continued From page 10 -She did not participate in any activities at the family care home. -There were no activities offered to residents during the day. -She would like to participate in some type of activity. -She had not been asked what type of activities she would like to participate in. Interview with a resident on 02/12/20 at 8:51am revealed: -There was not much to do at the facility. -She would like to see more activities carried out. -She watched television most of the time, "I wish I could get out more". Interview with Supervisor in Charge (SIC) on 02/12/20 at 3:38pm revealed: -She would try to encourage residents to participate in activities. -She would try to participate in activities with the residents two to three times a week. -Residents did not want to participate in activities. -She did not keep an activity log to track residents that participated in activities daily. -She did not ask residents for their input to suggest what type of activities they would like to participate in every six months. Interview with the Administrator on 02/12/20 at 3:52pm revealed: -He was responsible for printing the calendar and posting it on the dining room wall. -The staff should be encouraging residents during the day to so activities. -The current residents were not interested in activities. -Planned activities with the residents were not completed often due to their lack of interest. -He took the residents on outings to a restaurant	{C 291}		

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{C 291}	Continued From page 11 or store twice per month.	{C 291}		
{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 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 observation, record review and interview, the facility failed to administer medications as ordered by a licensed prescribing physician for 1 of 3 sampled residents (Residents #3) related to a mediation for smoking cessation. The findings are: 1. Review of Resident #3's current FL2 dated 06/03/19 revealed diagnoses included atypical chest pain, chronic obstructive pulmonary disease, and schizoaffective disorder. Review of Resident #3's signed physician's order dated 08/05/19 revealed Nicorelief gum 4mgto be chewed every hour. Review of Resident #3's December 2019 Medication Administration Record (MAR) revealed: -There was a handwritten entry for Nicorelief gum 4mg, chew one piece every hour, with no time	{C 330}		

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{C 330}	Continued From page 12	{C 330}		

indicated.
-Nicorelief gum was documented as administered 10 times from 12/01/19-12/31/19, there were no times indicated.

Review of Resident #3's January 2020 MAR revealed:
-There was a handwritten entry for Nicorelief gum 4mg, chew one piece every hour, with no time indicated.
-Nicorelief gum was documented as administered 80 times from 01/01/20-01/31/20, there were no times indicated.

Review of Resident #1's February 2020 MAR revealed:
-There was a handwritten entry for Nicorelief gum 4mg, chew one piece every hour, with no time indicated.
-There were no documented as entries for Nicorelief gum from 02/01/20-02/12/20.

Observation of medications on hand for Resident #3 on 02/12/20 at 1:59pm revealed:
-There was one package of 50 pieces of Nicotene 4mg chewing gum.
-There were 40 pieces of Nicotene 4mg chewing gum remaining.
-The Nicotene 4mg chewing gum was dispensed on 02/05/20.

Interview with a pharmacy representative on 02/12/20 at 2:08pm revealed:
-The pharmacy entered orders on the MAR, however the facility could write in orders that were not listed.
-The pharmacy had an order dated 08/05/19 for Nicorelief 4mg gum to be chewed every hour.
-The pharmacy had not entered the Nicorelief order onto the MAR.

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{C 330}	Continued From page 13 -The pharmacy dispensed 1 box of 50 pieces of Nicorelief gum on 08/05/19, 08/13/19, and 02/07/19. -Resident #3's medications were filled per the request of the resident or facility. Interview with Resident #3 on 02/12/20 at 2:06pm revealed: -He was prescribed nicotine gum to help him to stop smoking. -He did not know how often he was supposed to chew the gum. -He was given the gum once per day at various times. -The nicotine gum helped to curb his cravings for cigarettes. Interview with the supervisor in charge (SIC) on 02/12/20 at 2:08pm: -She administered medications to Resident #3. -She did not know why the Nicorelief gum was not administered as ordered. -Sometimes Resident #3 refused to take his medications, however there were times she forgot to document. -She did not know why the Nicorelief was not documented on the MAR correctly with the time indicated. -She did not know the exact time Resident #3 was to be administered the Nicotene. -Another SIC was responsible for handwriting medications on the MAR. -She did not realize the administration times were not listed on the MAR. Interview with the Administrator on 02/12/20 at 3:52pm revealed: -He expected medications to be administered as ordered. -Another SIC was responsible for handwriting	{C 330}		

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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
{C 330}	Continued From page 14 medication entries on the MAR. -He was responsible for making sure the MAR was clear. -He had not noticed the nicotine gum for Resident #4 was not administered as ordered. -He had not realized the nicotine gum was not written correctly on the MAR, "it was an oversight". Attempted interview with Resident #3's primary care provider (PCP) on 02/12/20 at 3:09pm was unsuccessful.	{C 330}		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060123	A. BUILDING: _____ B. WING _____	R 02/12/2020

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C 342	Continued From page 15 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records (MAR) were accurate and complete for 1 of 3 sampled residents (Residents #3) related to a mediation for smoking cessation. The findings are: 1. Review of Resident #3's current FL2 dated 06/03/19 revealed: -Diagnoses included atypical chest pain, chronic obstructive pulmonary disease, and schizoaffective disorder. Review of Resident #3's signed physician's order visit dated 08/05/19 revealed Nicorelief gum 4mgto be chewed every hour. Review of Resident #3's December 2019 MAR revealed: -There was a handwritten entry for Nicorelief gum 4mg, chew one piece every hour, with no time indicated. -Nicorelief gum was documented as administered 10 times from 12/01/19-12/31/19, there were no times indicated. Review of Resident #3's January 2020 MAR revealed: -There was a handwritten entry for Nicorelief gum 4mg, chew one piece every hour, with no time indicated. -Nicorelief gum was documented as administered 80 times from 01/01/20-01/31/20, there were no times indicated. Review of Resident #1's February 2020 MAR	C 342		

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C 342	Continued From page 16 revealed: -There was a handwritten entry for Nicorelief gum 4mg, chew one piece every hour, with no time indicated. -There were no documented entries for Nicorelief gum from 02/01/20-02/12/20. Interview with a pharmacy representative on 02/12/20 at 2:08pm revealed: -The pharmacy entered orders on the MAR, however the facility could write in orders that were not listed. -The pharmacy had an order dated 08/05/19 for Nicorelief 4mg gum to be chewed every hour. -The pharmacy had not entered the Nicorelief order onto the MAR. -The pharamcy could add the Nicotrelief gum to the MAR with proper administration times if requested by the facility. Interview with the supervisor in charge (SIC) on 02/12/20 at 2:08pm: -Sometimes Resident #3 refused to take his medications, however there were times she forgot to document. -She did not know why the Nicorelief was not documented on the MAR correctly with the time indicated. -She did not know the exact time Resident #3 was to be administered the Nicotene. -Another SIC was responsible for handwriting medications on the MAR. -She did not realize the administration times were not listed on the MAR. Interview with the Administrator on 02/12/20 at 3:52pm revealed: -Another SIC was responsible for handwriting medication entries on the MAR. -He was responsible for making sure the MAR	C 342		

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C 342	Continued From page 17 was clear. -He was responsible for reviewing the MARs monthly. -He had not realized the nicotine gum was not written correctly on the MAR, "it was an oversight". Attempted interview with Resident #3's primary care provider (PCP) on 02/12/20 at 3:09pm was unsuccessful.	C 342		
{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 02/12/20 at 9:45am revealed: -There was a small wooden cabinet, with 2 panels, located in the common living room, secured with a lock and chain through the	{C 353}		

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{C 353}	Continued From page 18	{C 353}		

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.
-The cabinet could be opened, and medications could be removed although there was a lock and chain through the handles.
-There were 5 plastic bins, labeled with the residents' names, containing the residents' medications.

Interview with the supervisor in charge (SIC) on 02/12/20 at 9:45am revealed:
-The residents' medications were always kept in the cabinet.
-She secured the cabinet with the lock and chain.
-The door of the cabinet had been broken from the hinges for some time, she could not say how long.
-The lock that was affixed to the cabinet panels did not actually secure the cabinet, since the right-hand panel was not on the hinges.
-She did not think the safety of the residents were of concern, because she was always present, observing the residents.

Observations on 02/12/20 at various times revealed:
-The residents passed through the common living area from their rooms.
-Two residents were 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 02/12/20 at 9:50am revealed:
-He knew medications had to be secured.
-He knew the panel of the medication storage cabinet was not properly secured.

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{C 353}	Continued From page 19 -He thought the lock and chain served to secure it. -He knew the panel was completely removed from the cabinet and the lock and chain did not secure the medication storage. -He was had some financial issues and had not been able to get the cabinet repaired.	{C 353}		