

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER MCLEOD FAMILY CARE CENTER OF FAYETTEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 248 LIVERMORE DRIVE FAYETTEVILLE, NC 28314
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 11/05/14.	C 000		
C 034	<p>10A NCAC 13G .0302(n) Design and Construction</p> <p>10A NCAC 13G .0302 Design and Construction (n) The home shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure current sanitation inspection reports were maintained in the home and available for review.</p> <p>The findings are:</p> <p>Interview with the Administrator on 11/05/14 at 3:10pm revealed the following:</p> <ul style="list-style-type: none"> - The Administrator was aware sanitation reports were to be current maintained in the home and available for review. - The Administrator stated sanitation inspection reports for the years of 2005, 2006, 2007 2009 and 2010 were available. - The Administrator stated the last sanitation inspection was completed in 2012 but she could not find the report. - The sanitation inspection for 2013 was not completed due to " conflicting schedules " of the Administrator and the county sanitation inspector. - The Administrator stated the county sanitation inspector had cancelled 3 appointment dates with 	C 034		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER MCLEOD FAMILY CARE CENTER OF FAYETTEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 248 LIVERMORE DRIVE FAYETTEVILLE, NC 28314
--	--

(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 034	<p>Continued From page 1</p> <p>the facility for the 2014 sanitation inspection. - The Administrator stated she would contact the county sanitation inspector and schedule an appointment for an onsite inspection as soon as possible.</p> <p>Review of the facility's sanitation inspection reports provided by the Administrator revealed the facility sanitation inspection reports for the years of 2005, 2006, 2007 2009 and 2010.</p> <p>The local county sanitation inspector was not available for interview.</p>	C 034		
C 202	<p>10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination</p> <p>10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 3 sampled residents (Residents # 1) was tested for tuberculosis (TB) disease upon admission to the facility according to the control measures adopted by the Commission for Health Services.</p>	C 202		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER MCLEOD FAMILY CARE CENTER OF FAYETTEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 248 LIVERMORE DRIVE FAYETTEVILLE, NC 28314
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 202	<p>Continued From page 2</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 4/03/14 revealed diagnoses which included diabetes, hypothyroidism, and post-traumatic stress disorder (PTSD).</p> <p>Review of the resident's Resident Register revealed an admission date of 3/27/12.</p> <p>Record review revealed the following:</p> <ul style="list-style-type: none"> - No documentation of TB skin test (1st step) completed upon admission. - No documentation of any TB testing completed after admission. <p>Interview with Resident #1 on 11/05/14 at 1:00pm revealed the following:</p> <ul style="list-style-type: none"> - The resident did not recall any TB testing done before or after admission to the facility. - The resident recalled having TB skin test several years ago at a facility before discharged home for a few weeks. - The resident did not remember date of TB skin test or date she was discharged home. <p>Interview with the facility's Administrator on 11/05/14 at 3:30pm revealed the following:</p> <ul style="list-style-type: none"> - Resident #1 was living at another facility for several years and had a 2-step TB skin test in 2008. - The resident was discharged from the other facility and lived at home for more than 1 month. - The resident was admitted to this facility on 3/27/14 and did not have the 1st step TB skin test and did not receive a TB skin test after admission. - The Administrator stated she thought the 2 step TB skin test from the former facility was ok. 	C 202		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

MCLEOD FAMILY CARE CENTER OF FAYETTEVILLE **248 LIVERMORE DRIVE**
FAYETTEVILLE, NC 28314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 202	Continued From page 3 - The Administrator stated she would schedule appointment foe Resident #1 to get 1st step TB skin test as soon as possible (in a few days).	C 202		