

Health Service Regulation

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

NAME OF PROVIDER OR SUPPLIER
MCLEOD FAMILY CARE CENTER OF FAYETTE

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	10A NCAC 13G .0302(n) Design and Construction 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. 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. The findings are: Interview with the Administrator on 11/05/14 at 3:10pm revealed the following: - 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	 <p>To correct Deficiency, The Dept of Public Health is to be contacted to schedule an appt. to have a sanitation inspection, by SIC Joyce McLeod.</p> <p>The date of the sanitation appt is 12/30/14. IF there is a change in the date, for any reason the SIC,</p>	12/30/14

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Joyce McLeod

SIC

12/19/14

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 11/05/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
MCLEOD FAMILY CARE CENTER OF FAYETTE

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	Continued From page 1 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. 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. The local county sanitation inspector was not available for interview.	C 034	<i>Joyce McLeod will contact you to NOTIFY you and to Give current updated information immediately TO prevent the problem from occurring again in the facility's Records will be checked in that area specifically on a quarterly basis. By the SIC, Joyce McLeod and two months prior to the sanitation report's expiration date... The Health Dept shall be called to schedule the sanitation inspection in advance then the prescheduled appt. shall be in place when the sanitation report file maintained on the premises.</i>	
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: 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.	C 202	<i>Also verification of having done the aforementioned shall be documented by SIC, Joyce McLeod This monitoring shall be done</i>	<i>Sanitation Inspection to be completed on 12/30/14 and the report forwarded to you by SIC, Joyce McLeod (910) 778-3569</i>

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 11/05/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER **MCLEOD FAMILY CARE CENTER OF FAYETTE** 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	<p>on a quarterly basis by SFC, Juyie Mikel, documented & maintained properly with sanitation FTL on the premises.</p> <p>Resident #1 was taken to Cumberland Co Dept of Health & Human Services on 11/25/14 Tues for TB Test. Upon arrival was told the scheduling had changed due to holiday season of Thanksgiving. I was told the earliest date I could return was Dec 1st</p> <p>Resident was taken to Comb Co Dept of HHSvc on Dec 1st /2014 for TB Test on returned for reading on 12/4/14. The outcome was a negative TB test. The first step of the two step has been completed</p> <p>The clinic stated to return on 12/15/14 to take the second TB test. Then it will be read on 12/18/14. Thus concluding the two step TB test for Resident #1.</p>	<p>Resident #1 Two Step TB Test to be completed 12/18/14 by SFC, Juyie Mikel (910) 778-3569</p>

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 11/05/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER: **MCLEOD FAMILY CARE CENTER OF FAYETTE**
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	Continued From page 3 - The Administrator stated she would schedule appointment for Resident #1 to get 1st step TB skin test as soon as possible (in a few days).	C 202	Resident #1 shall be taken to the Cumberland Co. Health Dept. to have a two step TB test administered, by SIC Joyce McLeod to correct the deficiency. To help prevent the problem from occurring again all staff will undergo training meeting to reiterate role knowledge of TB test + medical examination Also the format of admission policy manual to be taken into account when screening procedures are enacted will prominently include the guidelines to be followed Also each resident's records will be screened every quarter to assess the accuracy of his/her TB record and corrected accordingly. This monitoring practice shall be done quarterly by the SIC, Joyce McLeod and documented upon completion + kept on the premises of the facility.	

Herring, Belverly G

From: Kirby, Linda H
Sent: Wednesday, February 04, 2015 1:32 PM
To: feliciamitchell-mcneill@caccessnc.com
Cc: Coats, Tony; Herring, Belverly G
Subject: Mcleod FC Center 2014-12-09 POC
Attachments: McLeod Family Care Center 2014-12-09 POC OTO311.pdf

See Attachment.

Thanks,

Linda H. Kirby, RN, Nurse Consultant
North Carolina Department of Health and Human Services
Division of Health Service Regulation - Adult Care Licensure Section
109 West Main Street
Clinton, NC 28328
Office Phone: 910-592-293- Fax: 910-590-2516
Email: linda.kirby@dhhs.nc.gov
<http://www.ncdhhs.gov/dhsr/>

Email correspondence to and from this address is subject to the North Carolina Public Records Law and may be disclosed to third parties by an authorized State official. Unauthorized disclosure of juvenile, health, legally privileged, or otherwise confidential information, including confidential information relating to an ongoing State procurement effort, is prohibited by law. If you have received this email in error, please notify the sender immediately and delete all records of this email.