

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2015
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NAME OF PROVIDER OR SUPPLIER AGAPE FCH II	STREET ADDRESS, CITY, STATE, ZIP CODE 155 CARRIAGE LOOP BURLINGTON, NC 27217
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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 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on June 5, 2015.	C 000		
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 interview and record review, the facility failed to assure each resident had Tuberculosis (TB) disease testing upon admission to the facility in compliance with the control measures adopted by the Commission for Health Services for 1 of 3 (Resident #3) sampled residents.</p> <p>The findings are:</p> <p>Review of Resident #3's current FL-2 dated 1/13/15 revealed no admission date.</p> <p>Review of Resident #3's record revealed: -No documentation of an admission date to the facility. -Documentation of a TB skin test given on 3/28/14 and read as negative on 3/31/14.</p> <p>Resident #3 was not available for interview.</p>	C 202		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 202	<p>Continued From page 1</p> <p>Interview with the Manager on 6/5/14 at 5:30 p.m. revealed: -Resident #3 had his 1st step TB skin test in a prior facility. Resident #3 resided at another one of his facility, prior to being transferred to this facility. -He did not remember the exact date of Resident #3's admission date to this facility. -He was not aware that it had been over 12 months since Resident #3 had his 1st step TB skin test. -The facility's monitoring plan in place for residents TB skin tests was 1st step prior to admission and 2nd step within 30 days after admission. -He was responsible for the completion of the 2-step TB skin tests for all residents.</p> <p>The Administrator was not available for interview.</p>	C 202		