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 _____	06/30/2026

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 Lincsure Section conducted an annual survey on June 30, 2026.	C 000		
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 ensure referral and follow-up to meet the routine healthcare needs for 2 of 2 sampled residents related to notifying the provider of medications used to treat pain (#2) and a medication used to treat neurocognitive disorder (#3) that had not been available for administration. The findings are: 1. Review of Resident #2's current FL2 dated 01/06/26 revealed diagnosis of schizoaffective disorder. Review of Resident #2's Resident Register revealed an admission date of 01/05/26. a. Review of Resident #2's signed Primary Care Provider (PCP) order dated 03/03/26 revealed meloxicam (used to treat inflammation, stiffness and joint pain) 7.5mg by mouth daily with breakfast. Review or Resident #2's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for meloxicam 7.5mg by	C 246		

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C 246	Continued From page 1	C 246		

mouth daily with breakfast.
-On 04/01/26 through 04/18/26, meloxicam was documented as administered.
-On 04/19/26 and 04/20/26, meloxicam was documented as, "out of order, pharmacy aware."
-On 04/21/26 through 04/30/26, meloxicam was documented as, "out of order, doctor aware."

Review or Resident #2's May 2026 eMAR revealed there was no entry for meloxicam 7.5mg.

Review or Resident #2's June 2026 eMAR revealed there was no entry for meloxicam 7.5mg.

Review of Resident #3's record revealed there was no documentation that his PCP was notified of meloxicam not being available for administration.

Interview with Resident #2 on 06/30/26 at 12:07pm revealed he did not know he had not been receiving meloxicam.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/30/26 at 12:49pm revealed:
-The pharmacy last dispensed Resident #2's meloxicam on 04/01/26 for a 14 day supply.
-The pharmacy did notify the facility and Resident #2's PCP in April that a new prescription was needed to refill the resident's meloxicam.
-Resident #2 could experience increased pain levels if not taking meloxicam as ordered.

Refer to the interview with the Supervisor in Charge (SIC) on 06/30/26 at 12:38pm.

Refer to the interview with the Administrator on

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C 246	Continued From page 2 06/30/26 at 1:26pm. b. Review of Resident #2's signed PCP order dated 01/30/26 revealed ibuprofen (used to treat mild to moderate pain) 600mg by mouth twice daily. Review or Resident #2's April 2026 eMAR revealed: -There was an entry for ibuprofen 600mg by mouth twice daily at 8:00am and 8:00pm. -On 04/01/26 through 04/04/26 at 8:00am, ibuprofen was documented as administered. -On 04/04/26 at 8:00pm through 04/06/26 at 8:00am, ibuprofen was documented as, "out of order, pharmacy aware." -On 04/06/26 at 8:00pm through 04/30/26, ibuprofen was documented as, "out of order, doctor aware." Review or Resident #2's May 2026 eMAR revealed there was no entry for ibuprofen 600mg . Review or Resident #2's June 2026 eMAR revealed there was no entry for ibuprofen 600mg . Review of Resident #2's record revealed there was no documentation that his PCP was notified of ibuprofen not being available for administration. Interview with Resident #2 on 06/30/26 at 12:07pm revealed he did not know he had not been receiving ibuprofen. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/30/26 at 12:49pm revealed:	C 246		

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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 246	Continued From page 3 -The pharmacy last dispensed Resident #2's ibuprofen on 02/27/26 for a 30 day supply. -The pharmacy did notify the facility and Resident #2's PCP, date unknown that a new prescription was needed to refill the resident's ibuprofen. Refer to the interview with the SIC on 06/30/26 at 12:38pm. Refer to the interview with the Administrator on 06/30/26 at 1:26pm. Attempted telephone interview with Resident #2's PCP on 06/30/26 at 11:12am was unsuccessful. 2. Review or Resident #3's current FL2 dated 05/06/26 revealed: -Diagnosis of major neurocognitive disorder. -There was an order for risperidone (used to treat mental and mood conditions by balancing the brain's neurotransmitters) 1mg by mouth twice daily. Review or Resident #3's Resident Register revealed an admission date of 10/24/16. Review of Resident #3's April 2026 eMAR revealed: -There was an entry for risperidone 1mg by mouth twice daily at 8:00am and 8:00pm. -On 04/01/26 through 04/10/26 at 8:00am, risperidone was documented as administered. -On 04/10/26 at 8:00pm through 04/13/26 at 8:00pm, risperidone was documented as, "out of order, pharmacy aware." -On 04/14/26 at 8:00am through 04/23/26 at 8:00am, risperidone was documented as, "out of order, doctor aware." -Risperidone was documented as administered on 04/23/26 at 8:00pm through 04/30/26.	C 246		

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C 246	Continued From page 4 Review or Resident #3's May 2026 eMAR revealed: -There was an entry for risperidone 1mg by mouth twice daily at 8:00am and 8:00pm. -Risperidone was documented as administered from 05/01/26 through 05/23/26 at 8:00am. -On 05/23/26 at 8:00pm through 05/31/26, risperidone was documented as, "out of order, doctor aware." Review of Resident #3's June 2026 eMAR revealed: -There was an entry for risperidone 1mg by mouth twice daily at 8:00am and 8:00pm. -On 06/01/26 through 06/08/26 at 8:00pm, risperidone was documented as, "out, will be filled at doctors appointment." -On 06/09/26 at 8:00am through 06/29/26, risperidone was documented as, "out, doctor aware, no refills." Review of Resident #3's record revealed there was no documentation that her PCP was notified of risperidone not being available for administration. Interview with Resident #3 on 06/30/26 at 12:59pm revealed she was not aware that she had missed doses of her risperidone. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/30/26 at 12:49pm revealed: -The pharmacy dispensed Resident #3's risperidone on 03/10/26 for a 30 day supply and on 04/22/26 for a 30 day supply. -The pharmacy notified the facility and Resident #3's mental health provider, date unknown that a new prescription was needed to refill the	C 246		

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C 246	Continued From page 5 resident's risperidone. -Resident #3 could experience psychosis (a mental state described as a break from reality) and increased anxiety. Refer to the interview with the SIC on 06/30/26 at 12:38pm. Refer to the interview with the Administrator on 06/30/26 at 1:26pm. Attempted telephone interview with Resident #3's mental health PCP on 06/30/26 at 1:04pm was unsuccessful. _____ Interview with the SIC on 06/30/26 at 12:38pm revealed: -She knew Resident #2 and Resident #3 had been without their medications. -She was responsible for notifying the pharmacy and the PCP when resident medications were not available for administration. -She had contacted both Resident #2 and #3's PCPs when the medications ran out but was uncertain of the dates. -She did not have documentation of when she contacted the resident's PCPs. Interview with the Administrator on 06/30/26 at 1:26pm revealed: -She was aware that Resident #2 and Resident #3 had been out of their medications. -The SIC was responsible for ensuring all medications were available for administration and for notifying the PCP if medications were not available to be administered. -The SIC was responsible for ensuring prescriptions were obtained when needed by contacting the pharmacy and/or PCP.	C 246		

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C 330	Continued From page 6	C 330		
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 observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#2 and #3) related to medications to treat pain (#2) and a medication used to treat neurocognitive disorder (#3). The findings are: 1. Review of Resident #2's current FL2 dated 01/06/26 revealed diagnosis of schizoaffective disorder. Review of Resident #2's Resident Register revealed an admission date of 01/05/26. a. Review of Resident #2's signed Primary Care Provider (PCP) order dated 03/03/26 revealed meloxicam (used to treat inflammation, stiffness and joint pain) 7.5mg by mouth daily with breakfast. Review or Resident #2's April 2026 electronic medication administration record (eMAR)	C 330		

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C 330	Continued From page 7 revealed: -There was an entry for meloxicam 7.5mg by mouth daily with breakfast. -On 04/01/26 through 04/18/26, meloxicam was documented as administered. -On 04/19/26 and 04/20/26, meloxicam was documented as, "out of order, pharmacy aware." -On 04/21/26 through 04/30/26, meloxicam was documented as, "out of order, doctor aware." -Meloxicam was documented as administered for 18 out of 30 opportunities. Review or Resident #2's May 2026 eMAR revealed there was no entry for meloxicam 7.5mg. Review or Resident #2's June 2026 eMAR revealed there was no entry for meloxicam 7.5mg. Interview with Resident #2 on 06/30/26 at 12:07pm revealed he did not know he had not been receiving meloxicam. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/30/26 at 12:49pm revealed: -The pharmacy last dispensed Resident #2's meloxicam on 04/01/26 for a 14 day supply. -The pharmacy did notify the facility and Resident #2's PCP in April that a new prescription was needed to refill the resident's meloxicam. -Resident #2 could experience increased pain levels if not taking meloxicam as ordered. Refer to the interview with the Supervisor in Charge (SIC) on 06/30/26 at 12:38pm. Refer to the interview with the Administrator on 06/30/26 at 1:26pm.	C 330		

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C 330	Continued From page 8 b. Review of Resident #2's signed PCP order dated 01/30/26 revealed ibuprofen (used to treat mild to moderate pain) 600mg by mouth twice daily. Review or Resident #2's April 2026 eMAR revealed: -There was an entry for ibuprofen 600mg by mouth twice daily at 8:00am and 8:00pm. -On 04/01/26 through 04/04/26 at 8:00am, ibuprofen was documented as administered. -On 04/04/26 at 8:00pm through 04/06/26 at 8:00am, ibuprofen was documented as, "out of order; pharmacy aware." -On 04/06/26 at 8:00pm through 04/30/26, ibuprofen was documented as, "out of order; doctor aware." -Ibuprofen was documented as administered at 8:00am and 8:00pm for 7 out of 60 opportunities. Review or Resident #2's May 2026 eMAR revealed there was no entry for ibuprofen 600mg . Review or Resident #2's June 2026 eMAR revealed there was no entry for ibuprofen 600mg . Review of Resident #2's record revealed there was no documentation that his PCP was notified of ibuprofen not being available for administration. Interview with Resident #2 on 06/30/26 at 12:07pm revealed he did not know he had not been receiving ibuprofen. Telephone interview with the Pharmacist at the facilities contracted pharmacy on 06/30/26 at	C 330		

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C 330	Continued From page 9 12:49pm revealed: -The pharmacy last dispensed Resident #2's ibuprofen on 02/27/26 for a 30 day supply. -The pharmacy did notify the facility and Resident #2's PCP, date unknown that a new prescription was needed to refill the resident's ibuprofen. Refer to the interview with the SIC on 06/30/26 at 12:38pm. Refer to the interview with the Administrator on 06/30/26 at 1:26pm. Attempted telephone interview with Resident #2's PCP on 06/30/26 at 11:12am was unsuccessful. 2. Review or Resident #3's current FL2 dated 05/06/26 revealed: -Diagnosis of major neurocognitive disorder. -There was an order for risperidone (used to treat mental and mood conditions by balancing the brain's neurotransmitters) 1mg by mouth twice daily. Review or Resident #3's Resident Register revealed an admission date of 10/24/16. Review of Resident #3's April 2026 eMAR revealed: -There was an entry for risperidone 1mg by mouth twice daily at 8:00am and 8:00pm. -On 04/01/26 through 04/10/26 at 8:00am, risperidone was documented as administered. -On 04/10/26 at 8:00pm through 04/13/26 at 8:00pm, risperidone was documented as, "out of order; pharmacy aware." -On 04/14/26 at 8:00am through 04/23/26 at 8:00am, risperidone was documented as, "out of order; doctor aware." -Risperidone was documented as administered	C 330		

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C 330	Continued From page 10	C 330		

on 04/23/26 at 8:00pm through 04/30/26.
-Risperidone was documented as administered for 32 out of 60 opportunities.

Review or Resident #3's May 2026 eMAR revealed:
-There was an entry for risperidone 1mg by mouth twice daily at 8:00am and 8:00pm.
-Risperidone was documented as administered from 05/01/26 through 05/23/26 at 8:00am.
-On 05/23/26 at 8:00pm through 05/31/26, risperidone was documented as, "out of order; doctor aware."
-Risperidone was documented as administered for 45 out of 60 opportunities.

Review of Resident #3's June 2026 eMAR revealed:
-There was an entry for risperidone 1mg by mouth twice daily at 8:00am and 8:00pm.
-On 06/01/26 through 06/08/26 at 8:00pm, risperidone was documented as, "out, will be filled at doctors appointment."
-On 06/09/26 at 8:00am through 06/30/26 at 8:00am, risperidone was documented as, "out, doctor aware; no refills."
-Risperidone was documented as administered for 0 out of 59 opportunities.

Review of Resident #3's record revealed there was no documentation that his PCP was notified of risperidone not being available for administration.

Interview with Resident #3 on 06/30/26 at 12:59pm revealed she was not aware that she had missed doses of her risperidone.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/30/26 at

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C 330	Continued From page 11 12:49pm revealed: --The pharmacy dispensed Resident #3's risperidone on 03/10/26 for a 30 day supply and on 04/22/26 for a 30 day supply. -The pharmacy did notify the facility and Resident #3's mental health provider, date unknown that a new prescription was needed to refill the resident's risperidone. -Resident #3 could experience psychosis (a mental state described as a break from reality) and increased anxiety. Refer to the interview with the SIC on 06/30/26 at 12:38pm. Refer to the interview with the Administrator on 06/30/26 at 1:26pm. Attempted telephone interview with Resident #3's mental health PCP on 06/30/26 at 1:04pm was unsuccessful. _____ Interview with the SIC on 06/30/26 at 12:38pm revealed: -She knew Resident #2 and Resident #3 had been without their medications. -She was responsible for notifying the pharmacy and the PCP when resident medications were not available for administration. -She was responsible for ensuring medications were available for administration. Interview with the Administrator on 06/30/26 at 1:26pm revealed: -She was aware that Resident #2 and Resident #3 had been out of their medications. -The SIC was responsible for ensuring all medications were available for administration and for notifying the PCP if medications were not administered.	C 330		

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C 330	Continued From page 12 -The SIC was responsible for ensuring prescriptions were obtained when needed by contacting the pharmacy and/or PCP.	C 330		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record;	C 375		

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C 375	Continued From page 13	C 375		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure a licensed pharmacist, provider or registered nurse completed a quarterly on-site medication review for 1 of 3 sampled residents (#2).

The findings are:

Review of Resident #2's current FL2 dated 01/06/26 revealed diagnosis of schizoaffective disorder.

Review of Resident #2's Resident Register revealed an admission date of 01/05/26.

Review of Resident #1's record on 06/30/26 revealed there were no medication reviews available for review.

Telephone interview with the facility's contracted Pharmacist on 06/30/26 at 12:49pm revealed:
-He completed all medication reviews for the facility.
-He did not receive any information on Resident #2 to complete a medication review.

Interview with the Supervisor in Charge (SIC) on 06/30/26 at 12:38pm revealed:
-She was responsible for ensuring medication reviews were completed quarterly.
-She scheduled resident medication reviews with the contracted pharmacy when they were due.
-She thought the resident's medication review had been completed.

Interview with the Administrator on 06/30/26 at

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 _____	06/30/2026

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 375	Continued From page 14 1:26pm revealed: -She was not aware Resident #2 did not have a completed medication review. -The SIC was responsible for scheduling resident medication reviews and ensuring medication reviews were completed quarterly.	C 375		