PRINTED: 06/23/2015
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL044033	A. BUILDING: 01 B. WING _____	R 06/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCRACKEN REST HOME	203 MCCRACKEN STREET WAYNESVILLE, NC 28786

(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 Report of Follow-up Survey by Dennis Harrell on 6-5-2015. Some deficiencies were not corrected. Further action is required.	(C 000)	CONSTRUCTION SECTION JUL 23 2015 RECEIVED	
(C 189)	Building Equipment Maintained Safe, Operating SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1-Based on observation, the facility emergency illumination has not been maintained in a safe manner. This would effect all residents by not keeping the exits visible in an emergency. Findings on 03/10/2015: a. The emergency wall light between Rooms 3 & 4 did not illuminate when tested for emergency pack-up illumination condition. Findings on 6-5-2015: The light still did not illuminate when tested. 2-Based on observation, the facility has not maintained fire rated doors in a safe manner that did close completely in order to contain either smoke and/or fire.	(C 189)	Purchased a new emerg. light fixture, installed and working properly. 7/2/15	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Building Owner — (X6) DATE: 7/22/15

STATE FORM 6899 — COI322 — If continuation sheet 1 of 2

C. Copeland Supervisor 7-22-15

PRINTED: 08/23/2015
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(C 189)	Continued From page 1 Findings on 03/10/2015: a-The doors for Rooms 4 & 10 failed to latch. Findings on 6-5-2015: The door to room 10 still failed to latch.	(C 189)	Door repaired on 6/28/15. Working properly.	