STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL044046	A. BUILDING: _____ B. WING _____	R-C 01/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 000	Initial Comments The Adult Care Licensure Section and the Haywood County Department of Social Services conducted an annual and follow-up survey on January 4-6, 2017.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to remove appliances and surge protectors used as extension cords in one resident room (Room #8) as per the recommendation of the Fire Marshal. The findings are: Interview with the resident in room #8 on 1/4/17 at 9:10am revealed: -She cooked most of her meals in her room. -"It's therapy to me." Observation of resident room #8 on 1/4/16 at 10:06am revealed: -There was one two outlet receptacle located behind the resident's bed.	D 079	Per rule 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings: all appliances, with the exception of one microwave and one small Refrigerator have been removed from room #8. Surge protectors in place are one surge protector per wall outlet. A daily check list remains in place until re-inspection of Fire Marshall and frequent checks will → (CONT)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Connie Seely / Connie Seely — TITLE: Administrator — (X6) DATE: 1-30-17

Reviewed and Accepted
Date: 2/6/17 cs

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D 079	Continued From page 1 -There was a 5 outlet surge protector plugged into one of the two wall outlets. The 5 outlet surge protector had an additional 6 outlet surge protector plugged into it as well as a fan. -The 6 outlet surge protector had a scented wax warmer plugged into it as well as an alarm clock, cable receiver, flat screen television, and a stereo system. The alarm clock, cable receiver, and television were on. -A second 6 outlet surge protector was plugged into the second receptacle in the wall outlet. It had a microwave, two bulb floor lamp and a crockpot plugged into it. The microwave display was on and one bulb in the lamp was on. -Other appliances in the same area but not plugged in included a small refrigerator, a larger floor fan, and a second crockpot. Review of the facility's Fire Marshal's report dated 12/30/16 revealed: -"Remove extension cords in room #8." -"Remove cooking appliances in room #8." -The documented deadline to correct all violations was 1/31/17. Interview with the Administrator on 1/4/17 at 4:30pm revealed: -The Owner "had just been discussing how to talk with [the resident who lived in room #8] about unplugging some of her items. -"We were going to take some of the items out of her room." -"There is only one outlet with two plug-ins only in the room." -"I was not aware she had plugged surge protectors into other surge protectors." -"We will make sure only one surge protector is plugged into the wall." Telephone interview with the Fire Marshal on	D 079	to be observed thereafter to ensure electrical compliance and safety.	1-6-17

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D 079	Continued From page 2 1/5/17 at 9:06am revealed: -He had inspected the facility on 12/30/16. -"It is not safe to plug multiple surge protectors together." -He had found multiple appliances plugged into a two outlet wall receptacle in room #8. -The surge protectors "were not designed for that." -"Even if a single surge protector is plugged into a wall outlet, it can be overloaded as well." -"If an outlet is overloaded, it can cause a fire." -He had shown facility management the overloaded outlet in room #8 and it "should have been taken care of that day (12/30/16)" by decreasing the load on the outlets and removing the multiple surge protectors. -He had met with facility management on the day of the inspection and "discussed all the violations, so they were aware of the problems." Interview with the Executive Officer on 1/6/17 at 1:35pm revealed: -Room #8 now had only two surge protectors, each one plugged into an individual wall outlet. -He intended to contact the Fire Marshal and DHSR Construction to clarify what appliances the resident could have in her room. Observation of room #8 on 1/6/17 at 1:36pm revealed: -There were two surge protectors in the room. -There was one surge protector plugged into a wall outlet on the wall facing the back of the facility. -There was one surge protector plugged into a wall outlet on the wall facing the main hallway in the facility. --- The facility failed to remove appliances and surge	D 079		

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D 079	Continued From page 3 protectors used as extension cords in one resident room as per the recommendation of the Fire Marshal which resulted in an increased risk for overloading the electrical outlet in the room and increasing the risk for fire in the resident room which was detrimental to resident safety and constitutes a Type B Violation. _____ A plan of protection was received on 1/4/17 as follows: -Will immediately unplug appliances that are in surge protectors and any other electrical items in resident room #8. -One surge protector per wall outlet will remain in the room. -The resident room will be placed on a daily check list to ensure electrical compliance and safety. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 20, 2017.	D 079		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used.	D 299	Per rule: 10A NCAC 13F.0904(d)(3)(A). Nutrition And Food Services Based on Current Census of 13 residents, a minimum of 11 gallons of pasteurized milk will be supplied on a Weekly basis to allow for →	

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D 299	Continued From page 4 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to serve 8 ounces of pasteurized milk at least twice a day to residents of the facility. The findings are: Review of the facility's resident census for 1/4-6/17 revealed 13 residents resided in the facility (approximately one and two-thirds gallons of milk would be needed on a daily basis for 13 residents). Observation of the kitchen area on 1/4/17 at 9:29am revealed there was no pasteurized milk in the refrigerator. Review of the weekly menu spreadsheet posted on the refrigerator revealed milk was to be served at breakfast, lunch and dinner. Observation of the kitchen area on 1/4/17 at 12:05pm revealed there were 8 gallons of 2% pasteurized milk in the refrigerator. Confidential interviews with five residents during the initial facility tour regarding milk being offered at meals revealed: -"You have to ask for it and they will give it to you, unless they are low and the food truck is not here." -"I don't get none. Some of them do." -"If you ask for it. I see a lot of them get it. I drink tea most of the time." -"You can have milk at any meal if you ask for it." -One resident indicated staff offered him milk but he did not drink milk.	D 299	8 oz of pasteurized twice per day per resident ~~plus~~ and this includes a surplus 3 day emergency supply. at current censuds. This pasteurized milk supply will increase as census dictates	2-1-17

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D 299	Continued From page 5 Observation of the lunch meal service on 1/4/17 at 12:58pm revealed: -Ten residents were served lunch in the dining room. -None of the 10 residents were served milk. Confidential interviews with five residents after the lunch meal service on 1/4/17 revealed: -5 of 5 residents stated they had not been offered a serving of milk for lunch. -2 of 5 residents stated they would have drank a serving of milk for lunch if it had been offered to them. Interview with the cook on 1/4/17 at 2:40pm revealed: -The facility had run out of milk that morning. -Every Wednesday food is delivered to the facility. -They received 8 gallons of milk in today's delivery, "we get 8 gallons every week". -Residents were asked at each meal if they wanted milk. Observation of the kitchen area on 1/5/17 at 9:30am revealed there was 7.25 gallons of milk in the refrigerator. Observation of the kitchen area on 1/6/17 at 9:10am revealed there was 6.5 gallons of milk in the refrigerator. Review of the facility's weekly food delivery receipts from 11/2/16 through 1/4/17 revealed: -Of the 10 deliveries, 8 gallons of milk had been delivered eight times. -Four gallons were delivered twice. -Powdered milk had not been delivered. Interview with Staff B, Medication Aide, on 1/5/17 at 3:29pm revealed:	D 299		

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D 299	Continued From page 6 -Milk was offered to all residents at all meals. -"Only some of them will drink milk at certain times." -At breakfast, "two to three residents get milk. The others want orange juice. Both are offered, but the residents will refuse the milk and just want juice." -"One or two will drink milk at lunch. Most drink sweet tea or punch for lunch." -At supper, "one or two will drink milk. Most want sweet tea or punch." -"They have coffee at snack times in between meals." Interview with a second cook on 1/5/17 at 4:10pm and 1/6/17 at 11:11am revealed: -She normally prepared the lunch and dinner meal and "always offered milk" to the residents. -She used milk when preparing mashed potatoes, scalloped potatoes and pudding. -"I use a lot of milk to cook with," about "4 gallons" per week. Observation of the lunch meal service on 1/6/17 at 11:55am revealed: -Ten residents were served lunch in the dining room. -One resident had a serving of milk. Confidential interviews with three residents after the lunch meal service on 1/6/17 revealed all three had been offered milk. Review of menu selection form on 1/6/17 revealed a menu selection form that indicated personal menu preferences, including entrée or alternative choice, beverage choices and dessert option. Interview with the Administrator on 1/6/17 at	D 299		

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D 299	Continued From page 7 11:15am revealed: -They had used the menu selection form in the past. -She added the beverages choices section, which included milk as an option. -Residents will be asked to complete this for every meal. -Staff asked residents at each meal if they wanted milk.	D 299		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a minimum of 14 hours of planned group activities were provided each week, that promoted socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills for the residents currently	D 317	Per rule 10A NCAC 13F .0905(d) Activities Program: A minimum of 14 hours of Activities per week are now being offered and carried out by way of structured aide staff and hired of a part time Activity aide 2-2-17	

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D 317	Continued From page 8 living in the facility. The findings are: Review of the posted January 2017 Activity Calendar during the initial facility tour on 1/4/17 revealed the following planned activities during the survey: -On 1/4/17 from 9:00am-9:30am Exercise -On 1/4/17 from 10:00am-10:30am Snack Time -On 1/4/17 2:30pm Bingo with Rose -On 1/4/17 3:00pm-3:30pm Snack Time -On 1/5/17 from 6:00am-9:30am Morning Exercise -On 1/5/17 from 10:00am-11:00am Cooking Club -On 1/5/17 from 3:00pm-4:00pm Battle of the sexes Trivia -On 1/6/17 Shopping Day, All Day Pajama Party! -On 1/6/17 10:00am Words of the day -On 1/6/17 3:00pm Happy Hour Social -On 1/6/17 6:00pm Popcorn and Movie Observation of the activities as posted on the January 2017 activities calendar revealed: -On 1/4/17 the morning and afternoon snack time took place in the dining room, no other activities were observed from 9:00 am to 1:15pm or from 2:00pm to 5:00pm. -On 1/5/17 no activities were observed from 9:00am to 1:00pm (there were no activities in the afternoon due to a special service for the residents and staff that ran from 2:00pm to 4:00pm). -On 1/6/17 no activities were observed from 8:45am to 12:45pm or from 1:15pm to 3:00pm. Interviews with six residents on 1/4/17 from 9:00am to 11:00am during the initial tour revealed: -"The previous administrator did not have any	D 317		

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D 317	Continued From page 9 activities at all. The current administrator started activities when they first took over last year, but that did not last long and now we have no activities." -"They do not do activities here and if they had them I would join in." -"This place has improved 100% since the new administrator took over. We have several activities such as bingo, word games, movies, outings. A few of the residents want all the attention and the rest of us get little, but things are changing for the better and you can't do it all overnight." -"I don't join activities...I'm not very social. I just stay to myself." -"Exercise is offered. There's a lady that comes once a month to sing for us. We cut out stuff and color stuff. Stuff like that." -"They do bingo two times a week. A lady comes and sings for us once a month. The preacher comes every Sunday. Through the week we have a couple more things go on. It just depends on what day it is." Interviews with three residents on 1/6/17 from 10:30am to 11:00am revealed: -"We have activities like bingo and word games. They take place, but not when it says on the calendar." -"I enjoy bingo and word games. They do happen but the staff get very busy. There has been some staff turnover lately. I do like it here and the staff are all very nice. Sometimes the activities calendar is followed and sometimes it is not followed." -"I do not know if they have activities or not. I would not participate if they have any." Interview with the Administrator on 1/6/17 at 11:15am revealed:	D 317		

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D 317	Continued From page 10 -The Personal Care Aide who was recently "let go" did a "great job" doing many activities. -We have plans to start several new activities, but with several new staff we are working on getting some of them started. -"We let our Resident Care Coordinator (RCC) go last week and have a new RCC who started this week." -We also have a couple new staff and they look like they are going to work out. -We are in a transition time, but things are "looking up."	D 317		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult 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 assure 2 of 3 sampled residents (Resident #2 and #3) medications including narcotics, pain reliever, muscle relaxant, and inhaler were administered as ordered. The findings are: A. Review of Resident #3's current FL2 dated 11/8/16 revealed diagnoses included bipolar disorder, mood disorder, and anxiety.	D 358	Per rule 10A NCAC 13F .1004(a) Medication Administration All medication staff called to mandatory meeting to refresh re-order policy. 1-9-17 Medication Audit was Conducted immediately. 1-6-17 New RCC to conduct a Medication Audit →	

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D 358	Continued From page 11 Review of Resident #3's Resident Register revealed an admission date of 3/1/16. 1. Review of Resident #3's physician order sheet dated 7/19/16 revealed a physician's order for Percocet 10-325mg (used to treat pain) 1 tablet four times daily. Review of Resident #3's controlled drug re-evaluation form signed by a physician and dated 9/13/16 revealed Percocet 10-325mg 1 tablet four times daily for 120 tablets/1 month supply with no refills. Review of Resident #3's controlled drug re-evaluation form signed by a physician and dated 10/25/16 revealed Percocet 10-325mg 1 tablet four times daily for 120 tablets/1 month supply with no refills. Review of Resident #3's October 2016 Medication Administration Record (MAR) revealed: -A computer generated entry Percocet 10-325mg 1 tablet four times daily scheduled at 2am, 8am, 2pm, and 8pm. -Percocet 10-325mg was documented administered 121 occurrences out of 122 opportunities. -On 10/15/16 at 8:50pm, the reason documented for the medication not being administered was "on order from the pharmacy." Review of Resident #3's controlled drug re-evaluation form signed by a physician and dated 11/18/16 revealed Percocet 10-325mg 1 tablet four times daily for 120 tablets/1 month supply with no refills.	D 358	As well as E-MAR Reports to ensure MA documentation accuracy on a Bi-Weekly basis with results forwarded to Administration for review and Compliance.	2-1-17

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D 358	Continued From page 12 Review of Resident #3's November 2016 MAR revealed: -A computer generated entry Percocet 10-325mg 1 tablet four times daily scheduled at 2am, 8am, 2pm, and 8pm. -Percocet 10-325mg was documented administered 115 occurrences out of 120 opportunities. -On the following dates (11/15/16 at 7:49am, 11/15/16 at 2:13pm, 11/15/16 at 8:00pm, 11/16/16 at 1:53am, and 11/16/16 at 8:07am), the reason documented for the medication not being administered was "on order from the pharmacy." Review of Resident #3's signed physician order sheet dated 12/6/16 revealed a physician's order for Percocet 10-325mg 1 tablet four times daily. Review of Resident #3's controlled drug re-evaluation form signed by a physician and dated 12/6/16 revealed Percocet 10-325mg 1 tablet four times daily for 120 tablets/1 month supply with no refills. Review of Resident #3's December 2016 MAR revealed: -A computer generated entry Percocet 10-325mg 1 tablet four times daily scheduled at 2am, 8am, 2pm, and 8pm. -Percocet 10-325mg was documented administered 91 occurrences out of 93 opportunities. -On the following dates (12/16/16 at 8:31am and 12/16/16 at 1:51pm), the reason documented for the medication not being administered was "on order from the pharmacy." Review of Resident #3's January 2017 MAR from 1/1/17 to 1/4/17 revealed: -A computer generated entry Percocet 10-325mg	D 358		

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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
D 358	Continued From page 13 1 tablet four times daily scheduled at 2am, 8am, 2pm, and 8pm. -Percocet 10-325mg was documented administered 15 occurrences out of 15 opportunities. Observation of Resident #3's Percocet 10-325mg tablets on hand in the medication cart on 1/5/17 at 10:30am revealed there were 44 tablets available. Interview with Resident #3 on 1/5/17 at 10:55am revealed: -"I remember being out of Percocet, but it wasn't for very long." -"Most of the time when my medicine has run out it's not their fault, but the pharmacy's fault." -When the resident ran out of the Percocet "I'm in a lot of pain. It causes pain in my privates between my vagina and rectum...The doctor had told me it's my back that causes the pain..." -"I have to take the Percocet and Tramadol to control my pain." -"These do not take all the pain away, but it makes it bearable." Telephone interview with the facility's pharmacy on 1/5/17 at 3:29pm revealed: -The pharmacy had dispensed Percocet 10-325mg tablets in quantities of 120 tablets on 10/15/16, 11/16/16, and 12/16/16. -Their records for 11/16/16 indicated the facility had contacted them for a refill on 11/16/16 at 13:55pm and so the pharmacy would have delivered the Percocet between 8pm and 12pm on that day. -A prescription had been available for Resident #3 dated 11/10/16, so the pharmacy had not been awaiting an order from the physician to fill the Percocet.	D 358		

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D 358	Continued From page 14 Interview with Staff B, Medication Aide (MA), on 1/5/17 at 12:20pm revealed the Percocet not being on hand for Resident #3 for the occurrences in October, November, and December 2016 "could have been a script issue or it could have just ran out." Telephone interview with Resident #3's physician on 1/6/17 at 12:35pm revealed he did not feel her missing the Percocet on the occasions in October, November, and December 2016 were significant. Interview with Staff C, MA/Personal Care Aide, on 1/7/17 at 10:50am revealed: -On 10/15/16, "At 2pm, I noticed there were no more [Percocet] tablets and I put in an order. It must not have been here at 8pm. We receive pharmacy deliveries at all different times" of day. -"On that day the medicine may have been overlooked." -"If she runs out and we are waiting on the med, she also has Tramadol for pain prn." -"There's an on call pharmacy support if the prn didn't work, we could have contacted them." Refer to the interview with Staff B, Medication Aide (MA), on 1/5/17 at 12:12pm. Refer to the interview with Staff C, MA/Personal Care Aide, on 1/7/17 at 10:41am. Refer to the interview with the Administrator on 1/6/17 at 12:30pm and at 1:35pm. 2. Review of Resident #3's physician order sheet dated 7/19/16 revealed a physician's order for diclofenac potassium (used to treat pain) 50mg 1 tablet twice daily.	D 358		

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D 358	Continued From page 15 Review of Resident #3's current FL2 dated 11/8/16 revealed a physician's order for diclofenac potassium 50mg 1 tablet twice daily. Review of Resident #3's signed physician order sheet dated 12/6/16 revealed a physician's order for diclofenac potassium 50mg 1 tablet twice daily. Review of Resident #3's November 2016 MAR revealed: -A computer generated entry diclofenac potassium 50mg 1 tablet two times daily scheduled at 8am and 8pm. -Diclofenac potassium 50mg was documented administered 55 occurrences out of 60 opportunities. -On 11/28/16 at 8:00am through 11/30/16 at 8:00pm, the reason documented for the medication not being administered was "on order from the pharmacy." Review of Resident #3's December 2016 MAR revealed: -A computer generated entry diclofenac potassium 50mg 1 tablet two times daily scheduled at 8am and 8pm. -Diclofenac potassium 50mg was documented administered 59 occurrences out of 62 opportunities. -On 12/1/16 at 8:00am and 8:00pm and on 12/2/16 at 8:00pm, the reason documented for the medication not being administered was "on order from the pharmacy." Review of Resident #3's January 2017 MAR from 1/1/17 to 1/4/17 revealed: -A computer generated entry diclofenac potassium 50mg 1 tablet two times daily	D 358		

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D 358	Continued From page 16 scheduled at 8am and 8pm. -Diclofenac potassium 50mg was documented administered 7 occurrences out of 7 opportunities. Observation of Resident #3's diclofenac potassium tablets on hand in the medication cart on 1/5/17 at 10:30am revealed the medication was available for resident use. Interview with Resident #3 on 1/5/17 at 10:55am revealed: -"Most of the time when my medicine has run out it's not their fault, but the pharmacy's fault." -She was not aware if she had missed doses of the diclofenac potassium from 11/28/16 to 12/2/16. -"I don't know all of my medications." -"I don't know how it affected me or if it did missing those." Telephone interview with the facility's pharmacy on 1/5/17 at 3:29pm revealed: -Diclofenac potassium 50mg tablets had been dispensed for Resident #3 on the following dates and quantities (On 10/1/16 there were 28 tablets sent; on 10/15/16 there were 60 tablets sent, on 11/15/16 there were 62 tablets sent, on 12/15/16 there were 60 tablets sent.) -Since the diclofenac potassium was a scheduled medication, the pharmacy sent a 30 day supply of the medication for Resident #3. -"We fill those automatically." -"I can't believe it wasn't in the cycle. It could have been missed, but they should have called us to let us know it had not come." Telephone interview with Resident #3's physician on 1/6/17 at 12:35pm revealed he did not feel her missing the diclofenac potassium on the	D 358		

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D 358	Continued From page 17 occasions in November and December 2016 were significant. Refer to the interview with Staff B, Medication Aide (MA), on 1/5/17 at 12:12pm. Refer to the interview with Staff C, MA/Personal Care Aide, on 1/7/17 at 10:41am. Refer to the interview with the Administrator on 1/6/17 at 12:30pm and at 1:35pm. 3. Review of Resident #3's physician order sheet dated 7/19/16 revealed a physician's order for cyclobenzaprine (used to treat muscle spasms) 5mg 1 tablet three times a day as needed. Review of Resident #3's current FL2 dated 11/8/16 revealed a physician's order for cyclobenzaprine 5mg 1 tablet three times a day as needed. Review of Resident #3's signed physician order sheet dated 12/6/16 revealed a physician's order for cyclobenzaprine 5mg 1 tablet three times a day as needed. Review of Resident #3's October 2016 MAR revealed: -A computer generated entry cyclobenzaprine 5mg 1 tablet three times daily as needed. -Cyclobenzaprine 5mg was documented administered 55 occurrences. -There were four days when no doses were administered 10/21/16, 10/28/16, 10/29/16, and 10/30/16. Review of Resident #3's November 2016 MAR revealed: -A computer generated entry cyclobenzaprine	D 358		

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D 358	Continued From page 18 5mg 1 tablet three times daily as needed. -Cyclobenzaprine 5mg was documented administered 55 occurrences. -There were two days when no doses were administered 11/22/16 and 11/27/16. Review of Resident #3's December 2016 MAR revealed: -A computer generated entry cyclobenzaprine 5mg 1 tablet three times daily as needed. -Cyclobenzaprine 5mg was documented administered 48 occurrences. -There were four days when no doses were administered 12/9/16, 12/10/16, 12/11/16, and 12/19/16. Review of Resident #3's January 2017 MAR from 1/1/17 to 1/4/17 revealed: -A computer generated entry cyclobenzaprine 5mg 1 tablet three times daily as needed. -Cyclobenzaprine 5mg was documented administered 6 occurrences. Observation of Resident #3's cyclobenzaprine 5mg tablets on hand in the medication cart on 1/5/17 at 10:30am revealed there were 3 tablets available for resident use. Interview with Resident #3 on 1/5/17 at 10:55am revealed: -The facility had run out of her cyclobenzaprine "one time" recently. -"I believe the pharmacy was out of it." -"I don't remember the date." -"When I get the back spasms in my lower back, I fall down. So literally, I can't be without it." -"I remember it was out for a couple days." Telephone interview with the facility's pharmacy on 1/5/17 at 3:29pm revealed:	D 358		

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D 358	Continued From page 19 -The pharmacy did not have any indication the resident had ever been out of the cyclobenzaprine. -They had dispensed the medication to the facility for the resident on the following dates and quantities (On 10/7/16 there were 15 tablets sent; on 10/14/16 there were 15 tablets sent; on 10/21/16 there were 15 tablets sent; on 10/29/16 there were 15 tablets sent; on 11/1/16 there were 15 tablets sent; on 11/14/16 there were 15 tablets sent; on 11/22/16 there were 15 tablets sent; on 12/1/16 there were 15 tablets sent; on 12/12/16 there were 15 tablets sent; on 12/19/16 there were 15 tablets sent; and on 12/28/16 there were 15 tablets sent). -"A prn should never have been given like that anyway." -The facility really needed to check with the physician to see if the resident should have a scheduled order for the medication, since that was how it was being administered. Interview with Staff C, MA/Personal Care Aide, on 1/7/17 at 10:52am revealed: -She could not recall any instance when she had worked as a MA when Resident #3 had asked for the cyclobenzaprine and the medication had been unavailable. -"We try to make sure she doesn't run out, because she asks for it regularly." Telephone interview with Resident #3's physician on 1/6/17 at 12:35pm revealed he did not feel her not having doses of cyclobenzaprine on hand for a short period of time was significant. Refer to the interview with Staff B, Medication Aide (MA), on 1/5/17 at 12:12pm. Refer to the interview with Staff C, MA/Personal	D 358		

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D 358	Continued From page 20 Care Aide, on 1/7/17 at 10:41am. Refer to the interview with the Administrator on 1/6/17 at 12:30pm and at 1:35pm. 4. Review of Resident #3's physician order sheet dated 7/19/16 revealed a physician's order for Advair 250-50 diskus 1 puff two times a day. Review of Resident #3's current FL2 dated 11/8/16 revealed a physician's order for Advair 250-50 diskus 1 puff two times a day. Review of Resident #3's signed physician order sheet dated 12/6/16 revealed a physician's order for Advair 250-50 diskus 1 puff two times a day. Review of Resident #3's October 2016 MAR revealed: -A computer generated entry Advair 250-50 diskus 1 puff two times a day scheduled for 8am and 8pm. -Advair 250-50 was documented administered 62 occurrences out of 62 opportunities. Review of Resident #3's November 2016 MAR revealed: -A computer generated entry Advair 250-50 diskus 1 puff two times a day scheduled for 8am and 8pm. -Advair 250-50 was documented administered 59 occurrences out of 60 opportunities. -On 11/25/16 at 8:00am, the reason documented for the medication not being administered was "on order from the pharmacy." Review of Resident #3's December 2016 MAR revealed: -A computer generated entry Advair 250-50 diskus 1 puff two times a day scheduled for 8am	D 358		

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D 358	Continued From page 21 and 8pm. -Advair 250-50 was documented administered 60 occurrences out of 60 opportunities. Review of Resident #3's January 2017 MAR from 1/1/17 to 1/4/17 revealed: -A computer generated entry Advair 250-50 diskus 1 puff two times a day scheduled for 8am and 8pm. -Advair 250-50 was documented administered 7 occurrences out of 7 opportunities. Observation of Resident #3's Advair 250-50 diskus on hand in the medication cart on 1/5/17 at 10:30am revealed the medication was available for resident use. Interview with Resident #3 on 1/5/17 at 10:55am revealed: -"Most of the time when my medicine has run out it's not their fault, but the pharmacy's fault." -She did not remember if she had missed a dose of the Advair on 11/25/16. Telephone interview with the facility's pharmacy on 1/5/17 at 3:29pm revealed: -Advair 250-50 diskus had been dispensed for Resident #3 on the following dates and quantities (On 10/25/16 there were 60 disks sent; on 11/25/16 there were 60 disks sent, on 12/23/16 there were 60 disks sent.) -Since the Advair was a scheduled medication, the pharmacy sent a 30 day supply of the medication for Resident #3. -"We fill those automatically." Telephone interview with Resident #3's physician on 1/6/17 at 12:35pm revealed he did not feel the resident missing one dose of Advair as being significant.	D 358		

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D 358	Continued From page 22 Refer to the interview with Staff B, Medication Aide (MA), on 1/5/17 at 12:12pm. Refer to the interview with Staff C, MA/Personal Care Aide, on 1/7/17 at 10:41am. Refer to the interview with the Administrator on 1/6/17 at 12:30pm and at 1:35pm. B. Review of Resident #2's FL2 dated 9/27/16 revealed: -Diagnoses included bipolar disorder, vascular dementia, and CHF. -An order for Percocet 10-325mg (used to treat pain) 1 tablet twice daily. -An order for Percocet 10-325mg 1 tablet twice daily as needed for pain, not to exceed 2 tablets in 24 hours. Review of Resident #2's record revealed an admission date of 7/25/16. Review of Resident #2's controlled drug re-evaluation form signed by a physician and dated 9/13/16 revealed Percocet 10-325mg (used to treat pain) 1 tablet twice daily and 1 tablet twice daily as needed for pain, not to exceed 2 tablets in 24 hours, 60 tablets/ no refills. Review of Resident #2's controlled drug re-evaluation form signed by a physician and dated 10/25/16 revealed Percocet 10-325mg 1 tablet twice daily and 1 tablet twice daily as needed for pain, not to exceed 2 tablets in 24 hours, 60 tablets/ no refills. Review of Resident #2's October 2016 Medication Administration Record (MAR) revealed:	D 358		

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D 358	Continued From page 23 -A computer generated entry Percocet 10-325mg 1 tablet twice daily scheduled at 8am and 8pm. -Percocet 10-325mg was documented administered 60 occurrences out of 62 opportunities. -On 10/9/16 at 8:05am and on 10/25/16 at 7:57am, the reason documented for the medication not being administered was "on order from the pharmacy." Interview with Resident #2 on 1/4/17 at 9:32am and 1/5/17 at 11:50am revealed: -She was had run out of medications before, but it was "rare." -"I was out of my pain medication." -"I have an inoperable broken neck and it gives me a fit." -She had been out of pain medication the time before the last refill. -"I was out for 24 hours. I get two scheduled and three prns." -On 10/9/16 she did not receive her 8:00am scheduled dose. -On 10/25/16 she did not receive her 8:00am schedule dose, it was "about 4:00pm" when she received the next dose. -"I can't move my neck at all" when not receiving a dose of Percocet, it "really hurt". Review of the facility's pharmacy consolidated delivery sheets revealed 60 tablets of Percocet 10-325mg were delivered to the facility on 10/9/16 at 10:50am and on 10/25/16 at 1:33pm. Interview with Staff B, Medication Aide (MA), on 1/5/17 at 12:20pm revealed: -She was "not sure" for the reason Resident #2's Percocet was not on hand on 10/9/16, "it might have been cycle time, could have been a script issue or it could have just ran out".	D 358		

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D 358	Continued From page 24 -She did not recall Resident #2 being out of Percocet for 24 hours. Observation of Resident #2's Percocet 10-325mg tablets on hand in the medication cart on 1/5/17 at 11:30am revealed there were 54 tablets available. Telephone interview with Resident #2's physician on 1/6/17 at 12:35pm revealed he did not feel her missing the Percocet on the occasions in October 2016 were significant. Interview with Staff C, MA/Personal Care Aide, on 1/6/17 at 10:42am revealed: -When a medication is about to run out she would first look to see if another staff had made a reorder submission to the pharmacy. -She did not remember if she reordered Resident #2's Percocet on 10/25/16. -She could not "tell exactly" the reason Resident #2's Percocet ran out on 10/25/16, unless they were "waiting on the pharmacy" (to get a script for the physician). -Resident #2's Personal Care Physician (PCP) was "at the facility that morning (on 10/25) so "maybe (the pharmacy) was waiting for him (PCP) to write a script". -Resident #2 "needs her pain medication". Refer to the interview with Staff B, Medication Aide (MA), on 1/5/17 at 12:12pm. Refer to the interview with Staff C, MA/Personal Care Aide, on 1/7/17 at 10:41am. Refer to the interview with the Administrator on 1/6/17 at 12:30pm and at 1:35pm.	D 358		

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D 358	Continued From page 25 Interview with Staff B, Medication Aide (MA), on 1/5/17 at 12:12pm revealed: -She had worked as a MA in the facility since March of 2016, however she had just moved to day shift on 12/22/16. -Medications were reordered 7 days in advance of the medication running out. -"The bubble pack has a blue area which lets us know to reorder." -"There's a reorder button on each medication in [electronic MAR] and it allows you to add a note to the pharmacy." -"Sometimes the med comes the next day and sometimes it depends if they need a new script from the doctor." -"If the insurance would go through the backup pharmacy, we would use the backup pharmacy." Interview with Staff C, MA/Personal Care Aide, on 1/7/17 at 10:41am revealed: -During October, November, and December 2016, she had worked as an MA and "mainly days" and on "nights occasionally." -"Normally we request the medication 2 to 3 days before the resident runs out of the medication. The pharmacy is good about getting the meds here." -"We also have to fax hard copies of narcotic orders to the pharmacy and we do an electronic order to the pharmacy" for the medication. "The hard script" for the narcotic was then picked up later by the pharmacy during a delivery. Interview with the Administrator on 1/6/17 at 12:30pm and 1:35pm revealed: -She had recently had one MA "who we have let go." -The MA "would reorganize the medication cart so the other MA's may have had trouble finding some of the medications."	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL044046	A. BUILDING: _____ B. WING _____	R-C 01/06/2017

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
D 358	Continued From page 26 -A second MA had recently been removed from administering medications, due to not following proper procedures when documenting the medication administrations in the electronic MAR system. -She believed when the bubble pack was not properly scanned and a MA just used their finger to touch the screen to indicate to the electronic MAR system the medication had been administered it would cause problems with the pharmacy having the correct medication counts which would affect medication reordering. -The second MA had been properly retrained by pharmacy personnel however, continued not to follow proper procedures and so was removed from administering medications in December 2016. -The Administrator had not been aware medication supply being unavailable for the 3 sampled residents being a problem during October, November, and December 2016, however felt the problem would be solved with the changes she had made in staff.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure residents received care and services which are adequate,	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 27 appropriate and in compliance with relevant federal and state laws and rules and regulations related to housekeeping and furnishings. The findings are: Based on observations, interviews, and record reviews the facility failed to remove appliances and surge protectors used as extension cords in one resident room (Room #8) as per the recommendation of the Fire Marshal. [Refer to Tag D079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].	D912		