STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011369	A. BUILDING: _____ B. WING _____	R-C 01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANDLER LIVING CENTER	136 ROBINSON COVE ROAD CANDLER, NC 28715

(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 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual and follow-up survey on 01/02/19 to 01/03/19.	D 000		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure each table place setting included a nondisposable fork, knife, and a spoon. The finding are: Interview with the Resident Care Coordinator (RCC) on 01/02/19 at 8:45am revealed 29 residents resided in the facility. Observation of the lunch meal service on 01/02/19 from 11:50am to 12:15pm revealed: -There were 19 residents who were being served in the dining room. -The table place setting for all residents eating in the dining room consisted of a spoon, with no fork and knife.	D 287		

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D 287	Continued From page 1 -The residents were served 1 chicken patty, 1 serving of baked beans, 1 serving of mixed vegetables, 1 breadstick, and a piece of cake. -One resident held the chicken patty to his mouth in both hands to eat it. -A second resident was observed to have a plastic spoon with which to eat his meal. Interviews with five residents on 01/02/19 revealed: -All five of the residents had received only a spoon with which to eat their lunch. -"I would have used a fork if I had gotten one." -They were "sometimes" given a fork and a spoon to eat their meals. -They were "never" given knives in the place setting at meals. -One resident was unable to eat the chicken patty, because they did not have teeth and was unable to cut up the chicken patty. -"I got a plastic spoon. They don't give us metal utensils anymore." -"I had to eat spaghetti yesterday with a plastic spoon. I had to mash it up and cut into it. It still falls off the spoon. Plastic spoons just don't work." -"They say they run out of silverware." Interview with one personal care aide (PCA) on 01/02/19 at 2:05pm revealed: -The PCA had assisted to serve residents in the dining room during lunch meal service on 01/02/19. -The PCA did not know why forks were not included in the resident's place settings at the lunch meal service. -"Usually there's a spoon and fork." -Knives were included in place settings "sometimes."	D 287		

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D 287	Continued From page 2 Observation of the silverware on hand in the kitchen on 01/02/19 at 2:18pm revealed: -There were 34 forks available. -There were 12 knives available. -There were 27 tablespoons available. Interview with the Cook on 01/02/19 from 2:17pm to 2:27pm revealed: -"We have plenty of silverware." -Forks had not been provided for the resident's at lunch, because "they could not eat beans with a fork." -The chicken patty had not been cooked "hard," so it was easy for the residents to eat without use of a fork and knife. -If they were serving food items that required use of a fork (like salad or green beans), forks were provided. -"Some residents keep the plastic spoons" used for them on medication pass to eat with. -"They never told me to give all the residents a fork, knife, and spoon." -There were no teaspoon sized spoons available for use in the facility. -The tablespoon sized spoons were the only spoons available for use. -The resident's emptied their trays after each meal and they would sometimes accidentally throw away their utensils and dishes. -For instance, the facility had to order replacement bowls every other month due to resident's throwing them away. Interview with the Operations Manager on 01/02/19 at 2:50pm revealed: -She did not know the residents had received only a spoon in the place settings at lunch on 01/02/19. -"That should not be happening." -Staff were supposed to put out a full place	D 287		

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setting for each resident.
-She did not know there were not enough teaspoons and knives available in the facility.
-"Some of the residents take the silverware."
-"On Friday's we go around and gather up silverware" out of residents rooms.
-She would immediately get the silverware needed and have it for the place settings at "supper today."

Observation of the breakfast meal service on 01/03/19 from 8:00am to 8:25am revealed:
-There were 17 residents who were being served in the dining room.
-The table place setting for all residents eating in the dining room consisted of a plastic spoon.
-The residents were served 1 boiled egg, 1 serving of grits, a biscuit, orange juice, coffee, and all residents were offered milk.

Interviews with two residents on 01/03/19 revealed:
-"Sometimes we do get real spoons to eat with for breakfast and lunch."
-"We only get spoons. Just spoons to eat with."
-One resident had received a plastic spoon only with which to eat supper on 01/02/19.
-The staff used the plastic spoons because "it's cheaper that way and they don't have to wash them."

A second interview with the Operations Manager on 01/03/19 at 9:45am revealed:
-"Every resident had been assessed by their mental health providers and if they can't have a knife or fork it has to be in their care plan."
-"We don't have any residents that can't have a knife and fork."
-"I had a discussion with the kitchen last night."
-She did not know all the residents were given

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D 287	Continued From page 4 plastic spoons at breakfast on 01/03/19. -"It may have been the PCAs (personal care aides) who served this morning that didn't know" to put out a fork, knife, and spoon for all residents. -"It's a dignity issue." -"I made sure there were plenty of utensils in place for supper last night."	D 287		
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 administer medications as ordered for 1 of 3 sampled residents related to Zyprexa and Artane (Resident #2). The findings are:	D 358		

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D 358	Continued From page 5 Review of Resident #2's current FL2 dated 08/16/18 revealed diagnoses included psychosis, hypertension, chronic obstructive pulmonary disease, gout, and type 2 diabetes. a. Review of a psychiatry note dated 09/15/18 revealed: -The note was electronically signed by the mental health Nurse Practitioner. -There was documentation to consider switching Zyprexa (antipsychotic medication) to lurasidone (antipsychotic medication). -There were no orders to switch or discontinue the medication. Review of Resident #2's electronic Medication Administration record (eMAR) November 2018, December 2018, and January 1-3, 2019 revealed Zyprexa was not listed. Observation of Resident #2's medications on hand on 01/03/19 at 10:35am revealed Zyprexa was not present with the resident's other medications. Interview on 01/03/19 at 9:30am with the mental health Nurse Practitioner revealed: -Resident #2 should still be taking Zyprexa 7.5mg every day. -Resident #2 not receiving the Zyprexa could cause a decompensation of paranoia and withdrawal but "at the low doses nothing acute would occur". -The mental health Nurse Practitioner wrote the psychiatry note dated 09/15/18. Telephone interview on 01/03/19 at 9:35am with a representative from the facility's contracted pharmacy revealed: -The pharmacy had an original order for Zyprexa	D 358		

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7.5mg daily dated 06/30/15.
-The Zyprexa 7.5mg was last dispensed 06/21/18.
-On 06/24/18 the facility manually discontinued the Zyprexa from the eMAR.
-The pharmacy had no other Zyprexa orders.

Interview on 01/03/19 at 10:13am with Resident #2 revealed:
-He did not experience visual or auditory hallucinations.
-He felt calm.
-He sometimes "picked" at his skin.

Observation on 01/03/19 at 10:15am of Resident #2 revealed:
-He was laying on his bed and appeared calm.
-He had multiple round dried areas on his legs and arms from picking his skin.
-His tongue protruded slightly out of his mouth when he talked.

Interview on 01/03/19 at 10:20am with the Operations Manager revealed:
-The last day Resident #2 had received the Zyprexa was 06/24/18.
-The discontinued Zyprexa was an error due to the Resident Care Coordinator (RCC) entering an incorrect medication end date into the Electronic Medication Record (eMAR).

Interview on 01/03/19 at 10:25am with the RCC revealed:
-The last day Resident #2 had received the Zyprexa was 06/24/18.
-She did not know why she had discontinued the Zyprexa.
-She audits the eMAR weekly.

Interview on 01/03/19 at 10:55am with the Facility

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Manager revealed:
-The RCC and Operations Manager conduct weekly medication cart audits and monthly physician order audits.
-The Zyprexa was discontinued because of an error on the medication end date on the eMAR.

b. Review of a psychiatry note dated 09/15/18 revealed:
-There was an electronically signed physician order to increase Artane (used to treat extrapyramidal disorders) to 2mg.
-There were no additional orders for Artane.

Review of Resident #2's electronic Medication Administration Record (eMAR) for November 2018, December 2018, and January 1-3, 2019 revealed Artane was not listed.

Observation of Resident #2's medications on hand on 01/03/19 at 10:35 am revealed Artane was not present with the resident's other medications.

Interview on 01/03/19 at 9:30am with the mental health Nurse Practitioner revealed:
-The Artane was originally ordered 03/01/16.
-On 09/01/18, she had ordered the Artane be reduced from 2mg to 1mg every day.
-The hand written order was given to the staff of the facility to fax to the pharmacy.
-She did not know which staff she had given the order to.

Telephone interview on 01/03/19 at 9:35am with a representative from the facility's contracted pharmacy revealed:
-The pharmacy had an original order for Artane from 2016.
-The last order received was Artane 2mg give 1/2

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D 358	Continued From page 8 tablet every other day and bedtime then discontinue with a stop date of 12/07/17. -The pharmacy had no further Artane orders. Interview on 01/03/19 at 10:25am with the RCC revealed: -When the facility received physician recommendation orders they would call the physician to clarify the orders. -She did not know why this physician recommendation was not clarified, "I just missed it". -She audits the eMARs weekly. Interview on 01/03/19 at 10:20am with the Operations Manager revealed: -The orders for Artane were written in the form of progress note and the pharmacy would not accept it. -The Artane orders should have been clarified. Interview on 01/03/19 at 10:55am with the Facility Manager revealed: -The RCC and Operations Manager do weekly medication cart audits and monthly physician order audits. -The Artane order should have been clarified with the physician.	D 358		