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
	HAL044046	A. BUILDING: _____ B. WING _____	R 02/05/2020

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 000}	Initial Comments The Adult Care Licensure Section and the Haywood County Department of Social Services conducted a follow-up survey on 02/04/20 with an exit conference via telephone on 02/05/20.	{D 000}		
{D 131}	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with 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, NC 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and B) was tested for the tuberculosis (TB) disease with a two-step skin test in compliance with control measures adopted by the Commission for Public Health. The findings are: 1.Review of Staff B's personnel record revealed: -There was no official hire date for Staff C. -There was no documentation a first step or second step TB skin test was completed. Interview with Staff B on 02/04/20 at 12:55pm revealed: -He was not a hired employee of the facility. -He has volunteered in the kitchen "on and off	{D 131}	D131 NCAC 13F .0406(a) Test For Tuberculosis (Staff A) Has a current TB placed 10-24-19 and read negative on 10-26-19 All TB documentation will be reviewed by quarterly review check list to ensure documentation is current and according to state regulations D131 NCAC 13F .0406(a) Tests For Tuberculosis All "regular" volunteers shall be established with a volunteer file that includes documentation of TB Skin Test, Background check and personal healthcare registry documentation.	10-26-19 2-12-2020

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Connie Dooley — TITLE: Administrator — (X6) DATE: 3-10-2020

Reviewed and Accepted JTL 03/17/20

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{D 131}	Continued From page 1	{D 131}		

over the last two years."
-He did not complete any paperwork when he started volunteering at the facility.
-The Administrator would call when they needed someone to cover the duties of the kitchen.
-He did not remember getting a TB skin test.

Observation of the kitchen on 02/04/20 at 12:55pm revealed:
-Staff B was the only person working in the kitchen.
-Staff B was washing dishes and dating and wrapping food for storage in the kitchen.

Observation of the kitchen on 02/04/20 at 4:39pm revealed:
-Staff B was the only person working in the kitchen.
-Staff B was cooking meatloaf, noodles, and cauliflower.

Interview with the Administrator on 02/04/20 at 2:55pm revealed:
-Staff B was only a volunteer at the facility.
-She did not know he needed to have a TB skin test since he was only a volunteer.
-He was never officially hired by the facility.
-Staff B "volunteered" at the facility once monthly and sometimes less.
-She was responsible for making sure the staff qualifications were completed for each facility staff.
-She was responsible for auditing the staff records quarterly and as needed when new facility staff was hired.

2. Review of Staff A's personnel record revealed:
-Staff A was hired on 01/01/16 as the Administrator-In-Charge (AIC).
-There was documentation of a TB skin test

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{D 131}	Continued From page 2	{D 131}		

administered on 2/18/19, but no results were documented.
-There was documentation of a TB skin test administered on Thursday, 10/24/19, but the results were documented 7 days later on 10/31/19.

Interview with Staff A on 02/04/20 at 3:05pm revealed:
-He worked as the AIC for the facility but filled in where he was needed in the facility, including completed medication aide (MA) duties.
-His last TB skin test was administered in October, but he did not remember when the results were read.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 02/05/20 at 11:28am revealed:
-She administered a TB skin test to Staff A recently but could not remember the date.
-She was responsible for administering the TB skin test to the facility staff and residents.
-She administered the TB skin tests on Thursdays when she was at the facility.
-The results of the TB skin test were due on Saturday.
-She did not come to the facility on Saturday to read the results.
-She had the MA on duty text her a picture of the area the TB skin test was administered so she could interpret the results.
-She would document the results when she returned to the facility the following Thursday.

Interview with the Administrator on 02/04/20 at 2:55pm revealed:
-The facility's contracted NP was responsible for administering and reading the TB skin tests for the staff.

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{D 131}	Continued From page 3 -The NP came to the facility once weekly on Thursday. -The NP would come back to the facility on a Saturday if the results of a TB skin test needed to be read. -She was responsible for making sure the staff qualifications were completed for each facility staff. -She was responsible for auditing the staff records quarterly and as needed when new facility staff was hired.	{D 131}		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 1 sampled staff (Staff B) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR). The findings are: Review of Staff B's personnel record revealed: -There was no official hire date for Staff B. -There was no documentation of a HCPR check prior to the Staff working at the facility. Interview with Staff B on 02/04/20 at 12:55pm	D 137	D137 10A NCAC 13F .0407 Other Staff Qualiifications A volunteer file has been established to include TB documentation, Background check, healthcare personal registry and other regulatory documentation for "regular" volunteers.	2-12-2020

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D 137	Continued From page 4 revealed: -He was not a hired employee of the facility. -He has volunteered in the kitchen "on and off over the last two years." -He did not complete any paperwork when he started volunteering at the facility. -The Administrator would call when they needed someone to cover the duties of the kitchen. Interview with the Administrator on 02/04/20 at 2:55pm revealed: -Staff B was only a volunteer at the facility. -Staff B "volunteered" at the facility once monthly and sometimes less. -She did not know she needed to the check the HCPR for Staff B because he was a volunteer. -He was never officially hired by the facility. -She was responsible for making sure the staff qualifications were completed for each facility staff. -She was responsible for auditing the staff records quarterly and as needed when new facility staff was hired.	D 137		
{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: TYPE B VIOLATION	{D 358}	D 358 10A NCAC 13F .1004 Medication Administration. Medication reviews are now completed for all regular prescribed and PRN medications and or treatments bi-monthly as well as weekly narcotic inventory completed via GNP & Medication Aide to assure complete and accurate medication inventory. New procedures have been established with GNP, Pharmacy and facility Medication Aides to ensure that discharge summaries are review with three levels of accountability to ensure that discharge plans are reviewed	2-12-2020 2-12-2020

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{D 358}	Continued From page 5 Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents related to a medication to help the body pass kidney stones (Resident #2) and a medication to treat anxiety (Resident #1). The findings are: 1. Review of Resident #2's current FL2 dated 12/26/19 revealed diagnoses included anxiety, chronic obstructive pulmonary disease, congestive heart failure, malignant tumor of the lung, kidney stones. Interview with Resident #2 on 02/04/2020 at 10:20am revealed: -He had been admitted to the hospital twice within the last two months. -He was last admitted to the hospital about a month ago for kidney failure and dehydration. -He had been nauseated and vomited, did not drink enough, and it caused him to get dehydrated. -His roommate "looks after him" and alerted staff when something was wrong because he was a "bad diabetic" and had "heart problems". Review of Resident #2's hospital Discharge Summary orders for medications upon discharge dated 01/08/20 revealed: -There was an order to begin Flomax 0.4mg (used to help the help the body to pass kidney stones) take one capsule daily at bedtime. -The order had been reviewed by Resident #2's Nurse Practitioner (NP) at the facility with her initials signed at the bottom of the orders and dated 01/09/20.	{D 358}	(Continued from page 5) and followed per physicians orders.	

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{D 358}	Continued From page 6 Review of Resident #2's January and February 2020 electronic Medication Administration Record (eMAR) revealed there was no computer-generated entry for Flomax 0.4mg take 1 capsule daily at bedtime. Observation of medications on hand for Resident #2 on 02/04/20 at 3:37pm revealed there was no Flomax available to administer to Resident #2. Interview with the Medication Aide (MA)/Supervisor on 02/04/20 at 3:46pm revealed: -Resident #2 had a physician's order from the hospital discharge medication orders to begin Flomax 0.4mg take one capsule daily at bedtime and was reviewed by Resident #2's NP. -The order for Flomax for Resident #2 was not faxed to the pharmacy because "we must have missed it". -She was responsible for reviewing the Discharge Summary orders for Resident #2 when he was discharged from the hospital and readmitted to the facility. -Resident #2's Flomax had not been dispensed by the facility's contracted pharmacy. -She had not administered Flomax to Resident #2. Interview with the Administrator on 02/04/20 at 4:45pm revealed: -The MA/Supervisor was responsible for reviewing and faxing new medication orders to the pharmacy. -The MA/Supervisor was responsible for reviewing the Discharge Summary orders from the hospital and contacting the NP if there were new medications ordered for resident's. -The NP had reviewed the Discharge Summary orders dated 01/08/20 for medications for Resident #2.	{D 358}		

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{D 358}	Continued From page 7 -She did not know why the order for Flomax for Resident #2 was missed upon readmission to the facility and not faxed to the pharmacy. Telephone interview with Resident #2's Urologist on 02/05/20 at 10:05am revealed: -Resident #2 was not a surgical candidate to remove kidney stones. -She prescribed Resident #2 Flomax 0.4mg take 1 capsule twice a day for 90 days to assist him pass the kidney stones. -She faxed the prescription for Flomax for Resident #2 to his chosen local pharmacy on 02/03/20. -She did not know Resident #2 was prescribed Flomax when he was discharged from the hospital on 01/08/20. -Complications of Resident #2 not receiving Flomax included increased pain, nausea and vomiting, and possible infection. -Kidney stones could cause nausea and vomiting and could have attributed to dehydration in Resident #2. Telephone interview with the NP for Resident #2 on 02/05/20 at 11:15am revealed: -She last visited with Resident #2 on 01/30/20 and he was dehydrated, had nausea and vomiting, and his kidney function lab values were high. -She did not remember signing the medication order for Flomax from the first hospitalization for Resident #2 that she had reviewed on 01/09/20. -She sent Resident #2 to the hospital for a second time on 01/30/20 for an evaluation and made a referral for him to be seen by a Urologist. Telephone interview with a representative from the local pharmacy where Resident #2's prescription for Flomax was faxed on 02/05/20 at	{D 358}		

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{D 358}	Continued From page 8 12:15pm revealed: -They received a fax on 02/03/20 for a physician's order for Flomax 0.4mg take 1 capsule by mouth twice a day for 90 days. -Flomax had been dispensed for Resident #2 but had not been picked up by the facility. Telephone interview with the Administrator on 02/05/20 at 1:15pm revealed: -Resident #2 had been evaluated by the NP on 01/30/20 and was sent to the hospital for evaluation because he had decreased kidney function, nausea and vomiting, wasn't drinking enough fluids, and was dehydrated. -She did not know why Flomax had not been started for Resident #2 after his previous hospitalization. -The MA/Supervisor was responsible for reviewing new medication orders and calling the NP for any changes. -The NP will look at the physician orders and decide if the resident's should take them. -The NP will write a new order for the medications ordered by the hospital physician if she decided the resident needed the medication. Refer to the interview with the MA on 02/04/20 at 4:37pm. Refer to the interview with the Administrator on 02/04/20 at 4:50pm. 2. Review of Resident #1's current FL2 dated 02/17/19 revealed: -Diagnoses included traumatic brain injury, seizures, and anxiety. -There was a physician's order for Vistaril 25mg (used to treat anxiety) take as needed. Review of Resident #1's physician order sheet	{D 358}		

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{D 358}	Continued From page 9	{D 358}		

dated 12/12/19 revealed there was a physician's order for Vistaril 25mg take 1 capsule every 6 hours as needed.

Review of Resident #1's December 2019 and January 2020 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Vistaril 25mg take 1 capsule every 6 hours as needed scheduled to administer as needed.
-Vistaril was not documented as administered.

Review of Resident #1's February 2020 eMAR revealed:
-There was a computer-generated entry for Vistaril 25mg take 1 capsule every 6 hours as needed scheduled to administer as needed.
-Vistaril was not documented as administered.
-Resident #1 was out of the facility at the hospital during the medication pass on 02/03/20 at 8:00pm and on 02/04/20 at 8:00am.

Observation of medications on hand for Resident #1 on 02/04/20 at 12:30pm revealed there was no Vistaril available to administer to Resident #1.

Interview with Resident #1 on 02/04/20 at 1:10pm revealed:
-He was released from the hospital today and had just returned to the facility because he had a seizure yesterday (02/03/20).
-He had been under a lot of stress lately and stress is usually the trigger for his seizures.
-His stress level was building over the past week and makes him anxious.
-He did not know he had a physician's order for a medication he could use for his anxiety.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/04/20 at

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{D 358}	Continued From page 10	{D 358}		

12:45pm revealed:
-The pharmacy had never dispensed Vistaril to Resident #1.
-The pharmacy had a physician's order on file for Vistaril for Resident #1 with a written date of 01/21/19.
-The pharmacy started providing medications to the facility in January 2019.
-The facility was responsible for requesting the medications they needed to be dispensed initially based on the medications remaining from the previous pharmacy.
-She did not know why the facility had not requested the pharmacy to dispense Vistaril to Resident #1.

Interview with the medication aide (MA) on 02/04/20 at 4:37pm revealed:
-She did not know why Vistaril was not available on the medication cart to be administered to Resident #1.
-She assumed the medication had expired and was sent back to the pharmacy.
-Resident #1 never asked for the medication.

Telephone interview with a nurse from Resident #1's Neurologist's office on 02/04/20 at 3:38pm revealed:
-Resident #1 was followed by their office because of his seizures.
-She did not have Vistaril listed as a current medication for Resident #1.
-Resident #1 could have been started on Vistaril during a past hospitalization.
-Vistaril was used to treat anxiety.

Interview with the Administrator on 02/04/20 at 4:50pm revealed:
-She did not know Resident #1 did not have Vistaril available to be administered in the facility.

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{D 358}	Continued From page 11 -She did not know why the missing Vistaril was not discovered during a medication cart audit. Refer to the interview with the medication aide (MA) on 02/04/20 at 4:37pm. Refer to the interview with the Administrator on 02/04/20 at 4:50pm. _____ Interview with the medication aide (MA) on 02/04/20 at 4:37pm revealed: -She or the Administrator was responsible for faxing medication orders to the pharmacy. -She, the Administrator, or the Administrator-In-Charge (AIC) was responsible for approving the medication orders entered by the pharmacy to appear on the electronic Medication Administration Records (eMAR). -She was responsible for comparing the eMAR to the medication cart monthly to make sure all medications were available on the medication cart. Interview with the Administrator on 02/04/20 at 4:50pm revealed: -The MA was responsible for faxing medication orders to the pharmacy. -The pharmacy entered the medication order on the eMAR. -She, the AIC, or the MA was responsible for approving the medication orders entered by the pharmacy to appear on the eMAR. -She, the AIC, or MA was responsible for comparing the original medication order to the order entered on the eMAR before the order could be approved. -She, the AIC, or MA was responsible for auditing the medication carts monthly to make sure all medications were available to administer to the residents.	{D 358}		

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{D 358}	Continued From page 12 -She was responsible for completing a chart audit monthly. The facility failed to administer medications as ordered for 2 of 3 residents related to a medication to help the body pass kidney stones causing Resident #2 to have pain, nausea, vomiting, dehydration and abnormal kidney function lab values and putting the resident at an increased risk for infection. This failure was detrimental to the health, safety and welfare for the resident and constitutes a Type B violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 02/05/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 21 , 2020.	{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 ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are:	{D912}		

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 02/05/2020

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
{D912}	Continued From page 13 Based on observations, interviews, and record review, the facility failed to administer medications as ordered for 2 of 3 residents related to a medication to help the body pass kidney stones (Resident #2) and a medication to treat anxiety (Resident #1). [Refer to Tag 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]	{D912}	{D912} A Resident Council Meeting was held on 2-14-2020 to discuss all departments but focused on medication administration satisfaction and or concerns, allowing residents to voice opinions and ask questions regarding medication administration.	2-14-2020