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
	HAL044009	A. BUILDING: _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD LODGE AND RETIREMENT	251 SHELTON 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 an annual survey on February 17, 2016 and February 18, 2016.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for the 6 private resident rooms on the Maples hallway. The findings are: Observations on 2/17/16 during the initial tour revealed the Maples hallway had 6 private resident rooms (301-306). Room 302 was unoccupied, the remaining rooms had one resident per room. Observations on 2/17/16 from 9:55am to 10:10am revealed the following water temperatures:	D 113	D113 Thermostat on water heater servicing that Wing has been replaced. 2-22-16 Environmental service director will monitor temperatures each week x 3 for 1 month to ensure problem is resolved.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

ADMINISTRATOR 3/18/16

STATE FORM 6899 BD5211 If continuation sheet 1 of 13

REVIEWED & ACCEPTED
3/22/2016

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D 113	Continued From page 1 -Room 304 had a temperature of 122.0 at the bathroom sink. -Room 305 had a temperature of 119.1 at the bathroom sink. -Room 306 had a temperature of 119.3 at the bathroom sink. Interviews on 2/17/16 from 10:10am to 10:25am with the residents of rooms 304, 305 and 306 revealed: -All three resident's reported they had not been burned by the hot water. -All three residents verbalized understanding that the hot water was too hot in their rooms and that steps would be taken to lower the hot water temperatures. Further interviews on 2/18/16 from 9:45am to 10:20am with the Maple hallway residents in rooms 301, 304 and 306 revealed: -They had no complaints of elevated water temperatures. -They did not shower in their private bathroom. They preferred to bathe in the Spa shower room on the Retirement hallway. Interview on 2/17/16 at 10:30am with the maintenance supervisor revealed: -He had not been aware of the hot water temperatures. -He had checked the temperatures on the Maples hallway the first of the month and the temperatures were in the acceptable range. -No one had reported any adverse hot water temperatures to him. -When informed of the hot water temperatures he checked the system and found the thermostat on the hot water system for the Maples hallway was not working properly. He would immediately call a plumbing company and request they send	D 113		

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D 113	Continued From page 2	D 113		

someone out immediately to see what was wrong with the hot water heater.
-The hot water heater provided hot water to only the short hall that had six, single-occupancy rooms.
-He would monitor the water temperatures throughout the day.

Observation on 2/17/16 at 10:50am revealed the maintenance supervisor and an employee from a contracted plumbing company were working on the hot water system for the Maples hallway.

Interview on 2/17/16 at 10:50am with the employee from the contracted plumbing company revealed:
-He had already drained the hot water tank, refilled it and was waiting for it to return to temperature. It was set for 110-112 degrees F.
-The hot water system had an electronic thermostat.
-The thermostat set at 120 degree F.
-He explained when there was a power outage or power surge, the electronic thermostat would automatically reset at the factory setting of 120 degrees F.
-It was possible that during the recent winter weather events the thermostat could have been reset to the factory setting.
-There was no way to override the factory setting.
-The plumbing company employee stated he had just been at the facility last week, had checked all hot water systems and found the hot water temperatures to be between 110-112 degrees F. He did not keep documentation of the water temperatures.

Review on 2/18/16 of the facility's water temperature monitoring log revealed:
-Hot water temperatures were recorded as

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D 113	Continued From page 3 completed on a monthly schedule from 9/1/15 to 2/1/16 on the Maples hallway. -110 (degrees F) on 9/1/15 at 7:15am. -112 on 10/1/15 at 7:40am. -113 on 11/2/15 at 7:30am. -112 on 12/1/15 at 8:45am. -110 on 1/4/16 at 8:30am. -110 on 2/1/16 at 8:15am. Observations on 2/17/16 conducted with the maintenance supervisor revealed the following water temperatures on the Maples hallway: -98 (degrees F), bathroom sink in room 304 at 11:45am. -112, bathroom sink in room 303 at 12:31pm. -112, bathroom sink in room 304 at 12:38pm. On 2/17/16 at 2:30pm the maintenance supervisor informed the survey team the hot water temperatures were fluctuating and he had again called the plumbing company for assistance. As a precaution he posted in each residents bathroom on the Maples hallway a hot water warning sign above the bathroom sink. On 2/17/16 at 4:30pm the maintenance supervisor informed the survey team the issue had been found, a water valve had been inadvertently changed and the water temperatures were stable at around 107 degrees F. The hot water warning signs in each residents bath room would remain posted through the night. Observations on 2/17/16 at 5:00pm revealed the following water temperatures: -Room 304 had a reading of 109.6 at the bathroom sink. -Room 305 had a reading of 106.1 at the bathroom sink. -Room 306 had a reading of 104.1 at the bathroom sink.	D 113		

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D 113	Continued From page 4 Interview on 2/17/16 at 3:50pm with a Personal Care Aide (PCA) revealed: -She worked all three shifts and had worked with the residents on the Maples hallway. -She did not bathe residents in their private bathroom. She would bathe residents in the Spa/common bathroom on the Retirement hallway. -Before assisting a resident into the shower, she would check and adjust the water temperature. She would then ask the residents to "feel" the temperature of the water and adjust accordingly based on the resident's preferences. -She had not known of any elevated hot water temperatures on the Maples hallway. She would immediately report any elevated hot water temperatures to a supervisor or maintenance staff. Interview on 2/18/16 at 9:45am with the maintenance supervisor revealed the Spa shower room on the Retirement hallway was on a different hot water system than the Maples hallway. Observations on 2/18/16 at 9:55am and 2:45pm revealed the hot water temperature was 112 degrees F in the Spa shower room on the Retirement hallway. Observation on 2/18/16 at 11:24am revealed: -The maintenance supervisor's digital thermometer was calibrated in ice water and had a reading of 31.4 degrees F. -The surveyor's mercury thermometer was calibrated in ice water and had a reading of 32 degrees F. Observations on 2/18/16 conducted with the	D 113		

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D 113	Continued From page 5 maintenance supervisor using the surveyor's thermometer revealed the following water temperatures on the Maples hallway: -102 (degrees F), bathroom sink in room 304 at 9:45am. -100, bathroom sink in room 306 at 9:50am. -105, bathroom sink in room 306 at 10:20am. -107, bathroom sink in room 304 at 10:24am. -108, bathroom sink in room 301 at 10:28am. -113, bathroom sink in room 304 at 2:30pm. -104, bathroom sink in room 302 at 2:35pm. Interview on 2/18/16 at 2:40pm with the maintenance supervisor revealed he was unsure of the reason for the 9 degree difference in temperature between room 302 and 304. He would continue to monitor the hot water temperature and keep the hot water warning signs posted in each resident's bathroom until there was a steady temperature reading. Interview on 2/18/16 at 4:30pm with the Administrator revealed: -He supervised the maintenance supervisor. -He had not known of any hot water temperature issues on the Maples hallway prior to yesterday. -He knew the maintenance supervisor checked hot water temperatures on a monthly basis. -They would check hot water temperatures weekly.	D 113		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310	D310 Provide training to all cooks on puree textured food by RD. Training completed on 3-1-2016 Dietary manager & Administrator will monitor.	3-1-16

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D 310	Continued From page 6	D 310		

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to assure pureed diets for 2 of 2 residents (#1 and #2) were served as ordered by the residents' physician.

The findings are:

A. Review of Resident #1's current FL2 dated 04/30/15 revealed:
-Diagnoses included anxiety.
-Regular diet with chopped meats.
-No information regarding dentures or teeth.

Review of Resident #1's Care Plan dated 10/29/15 revealed the resident was on a regular diet with chopped meats.

Review of the physician diet order dated 01/26/16 revealed pureed, temporary change of diet until "teeth are found."

Review of Resident #1's diet order posted in the kitchen was pureed.

Observations during the lunch meal on 02/17/16 at 12:20pm revealed:
-Resident #1 was served 3 smalls bowls of food with a finely ground, thick, moist appearance.
-One bowl was meat with visible chunks.
-One bowl was potatoes with visible chucks.
-One bowl was cole slaw with visible chunks of carrots and cabbage.
-The resident was eating the food independently with no difficulty.

Review of the facility pureed menu for 02/17/16

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D 310	Continued From page 7 included: -4 ounces (oz) of pork chops. -4 oz of cheese potatoes. -4 oz of cabbage & apple salad with carrots. Interview with Resident #1 during the meal revealed no problems chewing or swallowing. Interview with the Primary Care Provider on 02/17/16 at 4:25pm revealed: -Resident #1 had no swallowing problems but did have problems chewing due to the recent loss of the resident's teeth. -After being placed on a pureed diet, the resident actually ate better and had gained some weight. Refer to interview with Cook A on 02/17/16 at 12:35pm. Refer to interveiw with the Dietary manager on 02/17/16 at 12:40pm. B. Review of Resident #2's current FL2 dated 08/25/15 revealed diagnoses included dementia. Review of the physician diet order dated 07/19/13 revealed: -"Change diet to regular pureed, if unsuccessful may go back to regular." -No information or diagnosis for the change. Review of Resident #2's diet order posted in the kitchen was pureed. Observations during the lunch meal on 02/17/16 at 12:20pm revealed: -Resident #2 was served 3 smalls bowls of food with a finely ground, thick, moist appearance. -One bowl was meat with visible chunks. -One bowl was potatoes with visible chucks.	D 310		

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D 310	Continued From page 8 -One bowl was cole slaw with visible chunks of carrots and cabbage. -The resident was being fed by Staff A (Personal Care Aide) and was swallowing with no difficulty. -The resident was spitting out the chunks of meat. Interview with Staff A on 02/17/16 at 12:25pm revealed: -Resident #2 had no swallowing problems but could not chew food well. -The pureed diet looked "OK" to her. -"[The resident] is spitting the meat out." Review of the facility pureed menu for 02/17/16 included: -4 ounces (oz) of pork chops. -4 oz of cheese potatoes. -4 oz of cabbage & apple salad with carrots. Based on diagnoses Resident #2 was determined to be non-interviewable. Interview with the Primary Care Provider on 02/17/16 at 4:25pm revealed: -Resident #2 did not have any swallowing problems. -The resident had problems chewing food due to poor dental condition and due to the resident's age/condition was not a candidate for dental work. Refer to interview with Cook A on 02/17/16 at 12:35pm. Refer to interview with the Dietary manager on 02/17/16 at 12:40pm. Interview with Cook A on 02/17/16 at 12:35pm revealed:	D 310		

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D 310	Continued From page 9 -He had pureed today's diets. -The proper consistency for pureed food should be "like mashed potatoes." -He thought today's pureed food "looked OK." -He did not know why the residents were ordered a pureed diet. Interview with the Dietary manager on 02/17/16 at 12:40pm revealed today's pureed food was chunky and course and not of the correct consistency. Observation of the lunch meal on 02/18/16 at 12:30pm revealed all pureed food items were served appropriately.	D 310		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to notify the County Department of Social Services (DSS) of accidents that required emergency medical evaluation for 2 of 2 residents with injuries after a fall (Residents #4 & #5). The findings are: A. Review of Resident 4's most current FL2	D 451	D451 Administrator will ensure that all residents involved in incidents or accidents requiring more than basic first aid will be reported to HCDSS Adult Home Specialist. Any resident being transported to another medical facility for examination due to incidents or accidents will be reported to HCDSS Adult Home Specialist. 2-18-16	

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D 451	Continued From page 10 dated 03/24/15 revealed diagnoses included Alzheimer's dementia. Review of an Incident & Accident (I & A) Report dated 01/24/16 at 8:30am revealed: -Resident #4 had fallen in the hallway. -The resident was transferred to the hospital and diagnosed with a hip fracture. -The resident's responsible party was notified. -No documentation that the County DSS was notified. Refer to interview with DSS on 02/18/16 at 2:00pm. Refer to interview with Staff Development Coordinator (SDC) on 02/18/16 at 4:00pm. Refer to interview the Resident Care Coordinator (RCC) on 02/18/16 at 4:05pm. Refer to interview with Administrator on 02/18/16 at 4:30pm. B. Review of Resident #5's most current FL2 dated 01/20/16 revealed diagnoses included generalized muscle weakness. Review of an I & A Report dated 12/31/15 at 6:37am revealed: -Resident #5 was found on the floor in the resident's room with "some lacerations" on knees and legs. -Vital signs were within normal limits. -The resident was "somewhat confused." -The resident was not taken to the hospital, however, first aide was administered. Interview with the SDC on 02/18/16 at 3:33pm revealed:	D 451		

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D 451	Continued From page 11 -Typically, she and the RCC (both were nurses), assessed a resident after an incident if there was an injury. -The SDC had assessed Resident #5 on 12/31/15 after the fall. -The SDC had noticed bruising on the resident's forehead, therefore the resident was sent to the Emergency Department (ED) for medical evaluation as a precaution. -The resident had returned to the facility the same day with no new issues or orders. -No documentation was found or provided regarding Resident #5's visit to the ED on 12/31/15. Refer to interview with DSS on 02/18/16 at 2:00pm. Refer to interview with SDC on 02/18/16 at 4:00pm. Refer to interview the RCC on 02/18/16 at 4:05pm. Refer to interview with the Administrator on 02/18/16 at 4:30pm. _____ Interview with the County's DSS staff on 02/18/16 at 2:00pm revealed: -DSS had only received two I &A reports for the entire year of 2015. -DSS had not received any I & A regarding Residents #4 or #5. Interview with the SDC on 02/18/16 at 3:55pm revealed: -Typically the SDC or the RCC would assess a resident after an incident with injury occurred (both were nurses).	D 451		

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D 451	Continued From page 12 -The Medication Aides filled out the I & A reports then gave them to the RCC. -She was not sure what the process was once the reports reached the RCC. Interview with the RCC on 02/18/16 at 4:05pm revealed: -The Medication Aides submitted the I & A reports to her. -She reviewed the I & A reports and followed up with staff and residents. -She would have the Primary Care Provider sign the reports. -The RCC then submitted the I & A reports to the Administrator who would then send them to DSS. -The RCC was not aware the I & A reports had not been sent to DSS. -She knew the County DSS was supposed to receive a copy of the I & A reports if a resident went to the hospital. Interview with the Administrator on 02/18/16 at 4:30pm revealed: -It was his responsibility to submit the I & A reports to DSS. -The Administrator stated, "it was on me" for failing to send the reports to DSS. -He sent I & A reports to DSS if a resident came back from the hospital with an injury that required further care. -He was "looking into ways" to improve the facility's I & A review process.	D 451		