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 _____	R 07/26/2018

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 conducted an annual and follow-up survey on July 25, 2018 through July 26, 2018.	D 000		
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 ensure a physician's order for thrombo-embolic-deterrent (TED hose), (used to prevent blood clots), a lidocaine transdermal patch and pramipexole (used for restless leg syndrome) were administered as ordered for 2 of 5 sampled residents (Resident #5 and #2). The findings are: 1. Review of Resident #5's current FL2 dated 06/21/17 revealed: -Diagnoses included type 2 diabetes, cerebral infarction, osteomyelitis of the tibia and fibula with an open wound, methicillin-resistant staphylococcus aureus (MRSA), hypertension, peripheral artery disease, heart failure, dementia and depression.	D 358		

Reviewed and accepted 8/31/18 RD

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D 358	Continued From page 1 a. Review of Resident #5's record revealed: -There was a six month physician review of the resident's medications dated 03/19/18. -There was an order for TED hose to be placed on at 8am and removed at 8pm. Observation on 07/25/18 at 4:00pm with a personal care aide (PCA) of Resident #5 revealed: -Resident #5 was lying in the bed. -Resident #5 did not have on TED hose but had on yellow gripper socks. Telephone interview on 07/26/18 at 11:11am a medication aide (MA) revealed: -He had worked last night (07/25/18). -He did not know there was an order for TED hose for Resident #5. -He did not remember seeing TED hose on Resident #5 on 07/25/18. -It was the responsibility of the PCAs to apply and remove the TED hose. -Sometimes the order for the TED hose would be on the electronic Medication Administration Record (eMAR) and sometimes it would not be. Interview on 07/26/18 at 11:30am with a second PCA revealed: -The Resident Care Coordinator (RCC) and the MAs were responsible for notifying the PCAs about any care needs a resident would have, including TED hose. -Sometimes their care needs "were not communicated". -Resident #5 was totally dependent upon staff for all her needs. -She was not aware of Resident #5 wearing TED hose. -She had never seen TED hose in her room.	D 358	Physician order was obtained for TED hose and placed on resident that day. 7.26.18 Med Techs and CNA's/PCA's were made aware. 7.26.18 Discussion had with Pharmacy that all Physician orders need to be placed on MAR and Pharmacy consultant will check quarterly. They will also add to drop down box in QMAR so RCC can also add. 7.26.18	

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D 358	Continued From page 2 -She had never applied TED hose on Resident #5. Interview on 07/26/18 at 11:30am with a third PCA revealed: -The RCC and the MAs were responsible for notifying the PCAs about any care needs a resident would have, including TED hose. -Resident #5 was totally dependent upon staff for all her needs. -She had never applied TED hose on Resident #5. -"We do everything for her except she is able to feed herself." -She was not aware of Resident #5 wearing TED hose. -She had never seen TED hose in her room. Interview on 07/26/18 at 11:45am with a fourth PCA revealed: -Resident #5 had contractures and it usually took two staff to assist her. -She was not aware of Resident #5 wearing TED hose. -Neither the RCC nor MAs had told her about Resident #5 wearing TED hose. -She had never seen TED hose in her room. -She had never applied TED hose on Resident #5. Observation on 07/26/18 at 1:40pm, with a MA, of Resident #5 revealed she did not have on TED hose. Interview on 07/26/18 at 1:50pm with the RCC revealed: -Resident #5 had an order for TED hose. -The order should have been sent to the pharmacy and the pharmacy should have transcribed the order to the eMAR.	D 358	Order written on Communication board for CNA's + PCA's. TED hose were also placed in resident's room for use. 7.26.18	

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D 358	Continued From page 3 -There was a communication board in the soiled utility room where she would inform staff of changes with residents such as orders for a TED hose. -She did not remember writing the order on the board. -She would pass the information on to the MA's for them to also tell the PCA's. Attempted telephone interview with the Nurse Practitioner (NP) on 07/27/18 at 11:11am was unsuccessful. Attempted telephone interview with the Administrator on 07/26/18 at 2:10pm was unsuccessful. b. Review of Resident #5's record revealed a physician's order for a lidocaine transdermal 5% patch, apply one patch every morning to intact skin of the right hip and one patch to the intact skin of the right knee and remove 12 hours later. Review of Resident #5's April 2018 electronic Medication Administration Record (eMAR) revealed: -An entry for lidocaine transdermal 5% patch, apply one patch every morning to intact skin of the right hip and one patch to the intact skin of the right knee and remove 12 hours later scheduled at 8:00pm. -The lidocaine transdermal 5% patch was documented as administered 6 occurrences out of 8 opportunities from 04/23/18 to 04/30/18. -On 04/27/18 at 8:00pm at 8:00pm, the lidocaine transdermal 5% patch was documented as not administered because of "resident refusal". Review of Resident #5's May 2018 eMAR revealed:	D 358	Pharmacy was advised if anything needs prior authorization to speak w/RCC so we can get medication to building 7.27.18	

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D 358	Continued From page 4 -An entry for lidocaine transdermal 5% patch, apply one patch every morning to intact skin of the right hip and one patch to the intact skin of the right knee and remove 12 hours later scheduled at 8:00pm. -The lidocaine transdermal 5% patch was documented as administered 27 occurrences out of 31 opportunities from 05/01/18 to 05/31/18 at 8:00pm. -On 05/9/18 at 8:00pm and 05/09/18 at 8:00pm, the lidocaine transdermal 5% patch was documented as "not given". -On 05/29/18 at 8:00pm, the lidocaine transdermal 5% patch was documented as not administered because of "resident refusal". Review of Resident #5's June 2018 electronic eMAR revealed: -An entry for lidocaine transdermal 5% patch, apply one patch every morning to intact skin of the right hip and one patch to the intact skin of the right knee and remove 12 hours later scheduled at 8:00pm. -The lidocaine transdermal 5% patch was documented as administered 29 occurrences out of 30 opportunities from 06/01/18 to 06/30/18 at 8:00pm. -On 05/21/18 at 8:00pm, the lidocaine transdermal 5% patch was documented as not administered because of "resident refusal". Review of Resident #5's July 2018 electronic eMAR revealed: -An entry for lidocaine transdermal 5% patch, apply one patch every morning to intact skin of the right hip and one patch to the intact skin of the right knee and remove 12 hours later scheduled at 8:00pm. -The lidocaine transdermal 5% patch was documented as administered 27 occurrences out	D 358	Medication sent to building STAT and patch applied to resident. immediately. 7.27.18 Meeting with all Med Tech's to inform them of this issue. Also spoke with pharmacy about issue. Pharmacy will add more drop down box reasons to MAR 7.30.18 Pharmacy consultant will be checking on quarterly visits. 7.30.18 RCC instructed to check orders in EMAR weekly also to ensure that orders are correct. 7.30.18	

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D 358	Continued From page 5 of 31 opportunities from 07/01/18 to 07/24/18 at 8:00pm. -On 07/03/18 at 8:00pm at 8:00pm, the lidocaine transdermal 5% patch was documented as not administered because of "resident refusal". -On 07/17/18 at 8:00pm and 07/22/18 at 8:00pm, the lidocaine transdermal 5% patch was documented as "not given". Telephone interview on 07/26/18 at 11:11am a second shift MA revealed: -He had worked last night (07/25/18). -He confirmed he documented he removed Resident #5's lidocaine transdermal 5% patch at 10:31pm on 07/25/18. -Resident #5 did not have any lidocaine transdermal 5% patches available for administration and he did not have a way to document it on the eMAR so he had been documenting that he had been removing the patch. Observation on 07/26/18 at 1:40pm of Resident #5's medications on hand revealed there were no lidocaine transdermal 5% patches available for administration for Resident #5. Interview on 07/26/18 at 1:40pm with the first shift MA revealed: -Staff were to use the closest option under the drop down box and then "I would make a note." -Staff could always put a note in explaining why they checked what they did. -Staff were not able to go back and read their own notes. -The drop down options for staff documentation were "given to family to give later, withheld per physician order, resident refused, physically unable to take, out of facility, medication spit out, awaiting physician assistant, first day on eMAR	D 358	Spoke with pharmacy data entry to work on drop down boxes to make available for med techs to be able to enter notes and check the notes that were entered. Corrected in eMAR. 7.30.18	

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D 358	Continued From page 6 documented on paper". Telephone interview on 07/26/18 at 10:37am with the facility's contract pharmacy revealed: -They had received an order for lidocaine transdermal 5% patch, apply one patch every morning to intact skin of the right hip and one patch to the intact skin of the right knee and remove 12 hours later. -The pharmacy had dispensed on 04/24/18 a quantity of 10 that had been purchased privately on 04/24/18. -The prescription for lidocaine required prior approval from Resident #5's insurance. -The pharmacy had sent a prior approval request to the NP and the RCC at the facility on 04/24/18 and 05/22/18. -The pharmacy had not received any response from the NP or the facility. -The pharmacy had not sent any more patches other than the original 10. -It was the physician's responsibility to get the prior approval. -The pharmacy was sending out 5 lidocaine transdermal 5% patches on 07/26/18 at the facility's request. Interview on 07/26/18 at 11:30am with a PCA revealed: -Resident #5 required a lot of care with her activities of daily living (ADLs) she experienced a lot of pain related to her physical condition through verbalization, facial grimacing and yelling out when moved. -Resident #5 was totally dependent upon staff for all her needs. -She was not aware of Resident #5 wearing a lidocaine transdermal patch. -She provided personal care to Resident #5 and if she had had a patch on she would have observed	D 358	Spoke with pharmacy prior approval request was never received. Sent 2nd request and had NPA to sign and returned.	7.27.18

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D 358	Continued From page 7 this in toileting or bathing. -She remembered Resident #5 having a patch for a few days but that was months ago. Interview on 07/26/18 at 11:30am with a second PCA revealed for revealed she did not remember Resident #5 having any transdermal patches on her when she provided personal care. Interview on 07/26/18 at 11:45am with a third PCA revealed: -Resident #5 had contractures and it usually took two staff to assist her. -She was not aware of Resident #5 wearing any transdermal patches. -She had never seen any transdermal patches on Resident #5. Interview on 07/26/18 at 1:50pm with the RCC revealed: -The MAs had not told her Resident #5 did not have any lidocaine transdermal 5% patches. -"The only thing" she was aware of was the pharmacy had been sending the transdermal patches a few at a time related to the residents insurance issues. -She had ordered a refill on 07/26/18 for Resident #5. -She had not received any faxes from the pharmacy Resident #5 needed prior approval. -She would have placed the prior approval form from the pharmacy directly in the facility's NP's box and fax it back to the pharmacy when the NP had signed the prior approval. -When the NP gave a new order, she would fax the order to the pharmacy, notified the MAs, and made changes on the cart by removing discontinued medications and adding new medications. -She would check the medications and eMAR	D 358	Facility had not received PA from pharmacy. Spoke with pharmacy about this. Pharmacy will send to PNP to sign. 7.30.18	

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D 358	Continued From page 8 periodically to make sure they were correct. -The MAs were trained to let her know if a resident ran out of their medication or was unable to have it available due to prior approval with the insurance company. -The MAs had not told her Resident #5 had not been receiving her transdermal patches since May 2018. -The facility would pay for any medication a physician ordered for a resident if they were awaiting prior approval. -She had not given approval for any lidocaine transdermal 5% patches for Resident #5 to be purchased by the facility for administration. -Staff "knew better than to be documenting they were giving a medication they didn't have in the building." -The MAs were trained to use "awaiting physician assistant" in the drop down box and let her know the medication was not available. Attempted telephone interview with the NP on 07/26/18 at 11:11am was unsuccessful. Attempted telephone interview with the Administrator on 07/26/18 at 2:10pm was unsuccessful. 2. Review of Resident #3's current FL2 dated 06/18/18 revealed: -Diagnoses included vascular dementia, hypertension, anxiety with depression, colon cancer, and coronary artery disease. -There was a physician's order for pramipexole 0.125mg every day at bedtime. Review of Resident #3's electronic Medication Administration Record (eMAR) for June and July 2018 revealed:	D 358	Spoke with Pharmacy Consultant and advised it will be checked quarterly.	7.30.18

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D 358	Continued From page 9 -There was an entry for pramipexole 0.125mg take one tablet at bedtime at 5:00pm. -There were 8 out of 9 doses documented as administered for June and 23 out of 25 doses administered for July. Review of Resident #3's medications on hand on 07/26/18 at 9:25am revealed: -There was one bottle labeled pramipexole 0.25mg take one tablet daily with a quantity of 90 tablets dispensed on 04/30/18. -There were ten whole tablets remaining in the bottle. -There was no other pramipexole bottles or bubble packs. Interview with a first shift medication aide (MA) on 07/26/18 at 9:30am revealed: -Resident #3 had brought in the bottle of pramipexole from home. -Once the tablets in the bottle were gone, the facility's pharmacy would dispense the pramipexole. -The MA was not aware if Resident #3 was given a whole tablet or one half tablet from the bottle because the MA did not work in the evening. Telephone interview on 07/26/18 at 9:42am with the dispensing pharmacy revealed they had dispensed pramipexole 0.25mg, 90 tablets, on 04/30/18. Telephone interview on 07/26/18 at 10:00am with the facility pharmacy revealed they had dispensed pramipexole 0.125mg, 30 tablets, on 06/21/18. Telephone interview on 07/26/18 at 11:15am with a second shift MA revealed: -He had been administering a whole tablet from	D 358	Spoke to Pharmacy. Time corrected in GMAR 7.26.18 Wasted tablets in bottle from home and ordered bubble pack from Pharmacy that day. Corrected MAR and bubble pack medication. Placed in cart today and explained to Med Tech. 7.26.18	

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D 358	Continued From page 10 the bottle labeled pramipexole 0.25mg to Resident #3 during his medication pass. -He knew there was no other bottles or bubble packs of pramipexole for Resident #3. -"The order (from 0.25mg to 0.125mg) may have changed and it was not communicated." -"I do read the MAR and compare." -He did not know he had been administering pramipexole 0.25mg instead of 0.125mg to Resident #3. Interview on 07/26/18 at 11:30am with the RCC revealed: -The MAs were trained to read the eMAR and compare to the label on the medication bottle or pack. -She did not know why the MA would "not give the correct dose". Interview on 07/26/18 at 11:35am with the Nurse Practioner (NP) revealed: -The NP had written an order "sometime around admission" to give pramipexole 0.25mg. -"She (Resident #3) should be getting her home dose." Review of physician order's for Resident #3 revealed there was no order for pramipexole 0.25mg. Interview on 07/26/18 at 1:15pm with Resident #3 revealed: -The Resident was not aware of the dose of pramipexole. -The Resident was not aware of what the pramipexole was for. Attempted telephone interview on 07/26/18 at 2:10pm with the Administrator was unsuccessful.	D 358	A changed order sticker was placed on medication bottle prior to use to show there was different dose on new PL-Z. Med Techs were educated concerning this. 7.26.18	

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D 482	Continued From page 11	D 482		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a	D 482		

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D 482	Continued From page 12 device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure physical restraints were used only after an assessment and care planning process had been completed through a team process and after alternatives had been tried and documented in the resident's record for 1 of 1 sampled residents (#1) who had a soft belt restraint. The findings are: Observation on 07/25/18 at 9:55am during the initial tour revealed: -Resident #1 was in a wheelchair in the hallway. -A soft belt restraint was around Resident #1's waist and tied in a bow at the back of the wheelchair. Review of Resident #1's current FL2 dated 04/24/18 revealed diagnoses included depressive disorder, insomnia, hypertension, and hypothyroidism. Review of a physician's order dated 02/10/18 revealed: -Resident #1 was to use a soft belt restraint while in the wheelchair and bed to prevent falls.	D 482		

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 _____	R 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 482	Continued From page 13 -The family of Resident #1 had requested the restraint to prevent falls. Review of Resident #1's current Care Plan dated 04/24/18 revealed: -Resident #1 was always disoriented with significant memory loss. -Resident #1 extensive assistance with activities of daily living and non-ambulatory. -There was no documentation of restraints. -There was no documentation of alternatives to the restraint. Review of Resident #1's Licensed Health Professional Support evaluation dated 04/09/18 revealed: -Resident #1 required the restraint due to falls. -There had been no falls since implementation of the restraint. Interview on 07/25/18 at 9:55am with a medication aide (MA) revealed: -Resident #1 wore the restraint at all times except when in bed. -The restraint prevented the resident from falling out of the wheelchair. Interview on 07/25/18 at 1:35pm with the Resident Care Coordinator (RCC) revealed: -The RCC had "missed" making sure restraints were part of the care plan for Resident #1. -"We have never done assessments for restraints, didn't know they needed to be done." -The facility Nurse Practitioner (NP) had "tried physical therapy and will be ordering a new chair" for Resident #1. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 482	New care plan written with correction of restraint. 7.26.18 New care plan done with correction. 7.26.18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 482	Continued From page 14 Attempted telephone interview with Resident #1's Power of Attorney on 07/25/18 at 1:55pm and 2:15pm was unsuccessful. Attempted telephone interview with the NP on 07/26/18 at 2:30pm was unsuccessful. Attempted telephone interview with the Administrator on 07/26/18 at 2:10pm was unsuccessful.	D 482	Physician orders are complete and clear explanation on how to use. Resident restraint check sheet filled in per CNA/PCA. Is complete with restraint instructions Administrator is ordering a Geri chair to eliminate restraint use.	7.26.18 7.26.18 8.30.18