Received via email 6/5/25 (TA)

PRINTED: 05/09/2025
FORM APPROVED

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 _____	R 04/23/2025

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 Haywood County Department of Social Services conducted an annual and follow-up survey on 04/22/25-04/23/25.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 3 of 3 staff sampled (Staff A, B, and D) who administered medications had completed the state approved 5-hour and 10-hour or 15-hour medication aide (MA) training courses as required. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired as an MA on 11/09/24. -There was documentation Staff A completed the medication administration clinical skills validation checklist on 01/31/25. -There was documentation Staff A passed the medication administration written exam on 05/12/08.	D 125	All employee must have all training and certifications before starting employment. Was able to obtain two staff members records of certifications of training. Also have medication class on 6/17/25 and 15 hour class training @ [redacted] Facility's contracted pharmacy 6/19/25 to 6/20/25 (TA) No employee is to administer meds before having 15hour medication class.	5/2/25 6/20/25

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

ADMINISTRATOR 6/2/25

STATE FORM 6899 U0MF11 If continuation sheet 1 of 16

Reviewed + Acknowledged + Revised per telephone conversation on 6/5/25 @ 3:15pm
6/5/25 @ 3:19pm.

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D 125	Continued From page 1 -There was no documentation Staff A completed the state approved 5 and 10, or 15-hour MA training course. Attempted telephone interview with Staff A on 04/23/25 at 5:00pm was unsuccessful. Interview with the Human Resources Manager on 04/23/25 at 5:11pm revealed: -There was no documentation in Staff A's personnel record that the 5 and 10, or 15 hour MA training course had been completed. -Staff A came to work as an MA from another facility. Refer to interview with the Administrator on 04/23/25 at 5:06pm. 2. Review of Staff B's personnel record revealed: -Staff B was hired as an MA on 12/19/24. -There was documentation Staff B completed the medication administration clinical skills validation checklist on 12/23/24. -There was documentation Staff B passed the medication administration written exam on 12/01/15. -There was no documentation Staff B completed the state approved 5 and 10, or 15-hour MA training course. Interview with Staff B on 04/23/25 at 4:49pm revealed: -She was hired at the facility in December 2024 as a medication aide (MA). -She did not complete the 5-hour and 10-hour or 15-hour MA training course upon being hired. -She completed the 15 hour MA training course about 7 years ago when she worked for a sister facility. -She did not continously work as a MA after she	D 125		

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D 125	Continued From page 2 became a MA. Interview with the Human Resources Manager on 04/23/25 at 5:11pm revealed: -There was no documentation in Staff B's personnel record that the 5 and 10, or 15 hour MA training course had been completed. -Staff B came to work as an MA from another facility. Refer to interview with the Administrator on 04/23/25 at 5:06pm. 3. Review of Staff D's personnel record revealed: -Staff D was hired as an MA on 10/02/23. -There was documentation Staff D completed the medication administration clinical skills validation checklist on 10/07/23. -There was documentation Staff D passed the medication administration written exam on 04/26/23. -There was no documentation Staff D completed the state approved 5 and 10, or 15-hour MA training course. Attempted telephone interview with Staff D on 04/23/25 at 5:00pm was unsuccessful. Interview with the Human Resources Manager on 04/23/25 at 5:11pm revealed: -There was no documentation in Staff D's personnel record that the 5 and 10, or 15 hour MA training course had been completed. -Staff D was no longer an employee of the facility. Refer to interview with the Administrator on 04/23/25 at 5:06pm. Interview with the Administrator on 04/23/25 at 5:06pm revealed:	D 125	Will assure that all paperwork is in employee files before adminstering meds.	5/2/25

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D 125	Continued From page 3 -He was not aware verification of the 5 and 10, or 15-hour MA training course was not in the MAs personnel record. -He was sure all three MAs had completed the 5 and 10, or 15-hour MA training course or they would not be passing medications. -The Human Resources Manager was responsible to ensure required paperwork was placed in each staff member's personnel record.	D 125		
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 Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#5) related to medications used to treat bacterial infections. The findings are: Review of Resident #5's current FL2 dated 09/27/24 revealed diagnoses included unspecified dementia without behavioral disturbance, diabetes type 2, and history of bowel	D 358	Educated all med techs that they are required to follow all physician orders. Explained to med techs that when orders are received from physician it must be sent to pharmacy for order to be entered into computer whether we get meds from Facility's contracted [redacted] pharmacy or another pharmacy. Once order is faxed to pharmacy order is approved per RCC and med tech should check	4/23/25

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D 358	Continued From page 4 blockages. a. Review of Resident #5's emergency department (ED) report dated 03/08/25 revealed: -Resident #5 was admitted to the hospital with a chief complaint of urinary tract infection (UTI). -Resident #5 had benign prostatic hyperplasia [(BPH) prostate gland enlargement that can lead to urinary problems], and a chronic indwelling Foley catheter. -Resident #5 presented with a UTI and pre-renal azotemia (a condition characterized by abnormally high levels of nitrogen waste products in the blood, resulting from reduced blood flow to the kidneys). Review of Resident #5's hospital discharge instructions dated 03/10/25 revealed: -There was an order that was submitted electronically by the physician for cefpodoxime 200mg (an antibiotic used to treat bacterial infections in the body), one tablet twice daily with meal/food. -The provider did not document how long cefpodoxime 200mg should be taken. -The provider did not document when to start taking cefpodoxine 200mg. Review of Resident #5's home health note dated 04/03/25 revealed: -Resident #5's Foley catheter had yellow urine with sediment and small blood clots observed. -Heavy white discharge from penis observed. Review of Resident #5's history and physical report dated 04/06/25 revealed: -Resident #5's chief complaint was worsening confusion. -Resident #5 had BPH and a chronic indwelling Foley catheter.	D 358	Cont: med carts to assure all meds are in med cart drawer for administering. IF for any reason medication did not come, med techs are to notify PCP and RCC immediately.	4/23/25

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D 358	Continued From page 5 -He was admitted for inpatient treatment. -Lab work revealed cystitis (inflammation of the bladder), (often caused by bacterial infection and elevated lactic acid level), requiring intravenous fluids. Telephone interview with a representative from the facility's contracted pharmacy on 04/23/25 at 10:23am revealed: -An order was received for Resident #5 on 03/10/25 for cefpodoxime 200mg, take twice daily. -A 7-day supply was dispensed on 03/10/25. Review of Resident #5's March 2025 electronic Medication Administration Record (eMAR) revealed: -There was no entry for cefpodoxime 200mg, twice daily. -There was no documentation cefpodoxime 200mg was administered on 03/10/25- 03/17/25. Telephone interview with Resident #5's Power of Attorney (POA) on 04/23/25 at 10:00am revealed: -She remembered picking up an antibiotic from a local pharmacy, which was a different pharmacy than who the facility contracted with, about a month ago and taking the medication to the facility for Resident #5. -She gave the medication to a staff member. Telephone interview with Resident #5's primary care provider's (PCP's) Registered Nurse (RN) on 04/23/25 at 2:30pm revealed: -She was notified Resident #5 had a hospital visit. -She did not know of any new medications Resident #5 was prescribed. -If Resident #5 did not receive cefpodoxime as prescribed, it could lead to worsening symptoms and could cause Resident #5 to become septic	D 358		

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D 358	Continued From page 6 (inflammation throughout the body that could damage organs, causing the organs to fail and could lead to death). Interview with a medication aide (MA) on 04/23/25 at 10:36am revealed: -When orders were filled at other local pharmacies, the MAs filled out a sheet and faxed it to their contracted pharmacy and would ask the pharmacy "not to send the medication," but only add to the eMAR. -The contracted pharmacy would add the medication to the eMAR. -When other pharmacies were used, they never administered the medication unless it had been added to the eMAR. -She did not remember administering cefpodoxime 200mg to Resident #5. -She was not sure why the medication never got added to the eMAR. Interview with a second MA on 04/23/25 at 1:51pm revealed: -She did not know how medications got added to the eMAR when they came from other pharmacies besides the contracted pharmacy. -If they received medications and the medication were not already on the eMAR, she would report to the Resident Care Coordinator (RCC). -She never administered cefpodoxime 200mg to Resident #5. -She was not sure how the medication got missed. Interview with a third MA on 04/23/25 at 3:02pm revealed: -When medications were filled at other pharmacies, besides the facility contracted pharmacy, the MAs wrote the medication down and faxed the contracted pharmacy to request the	D 358		

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D 358	Continued From page 7 medication be added to the resident's eMAR. -She had never given medications if they were not listed on the eMAR. -She did not remember Resident #5 having an order for cefpodoxime 200mg. -The RCC approved all medications that came from the hospital. -She was not sure how it got missed. Interview with a fourth MA on 04/23/25 at 3:10pm revealed: -When medications were filled at other pharmacies, besides the facility contracted pharmacy, the MAs wrote the medication down and faxed the contracted pharmacy to request the medication be added to the resident's eMAR. -She remembered Resident #5's POA bringing in cefpodoxime 200mg. -She was told about Resident #5's POA bringing the medication in during shift report. -She did not remember who the medication was given to. -She did not remember administering the medication to Resident #5. Interview with the RCC on 04/23/25 at 11:27am and 3:36pm revealed: -She was not sure what happened with the cefpodoxime 200mg that was prescribed to Resident #5. -The MAs should tell her if medications were not on the eMAR. -The MAs call the contracted pharmacy or fax a sheet to them for the pharmacy to add medications to the eMAR. -The MAs should check to make sure the medication was on the eMAR before administering it. -If the medication was not on the eMAR, the MA should have asked for a paper MAR to document	D 358		

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D 358	Continued From page 8 the medication was administered while waiting for the medication to be added to the eMAR. -There was no documentation cefpodoxime 200mg was administered. -She did not know what happened to the medication. -It was her responsibility to go back through orders and check for accuracy. Interview with the Administrator on 04/23/25 at 11:34am 3:45pm revealed: -The MA faxed orders to the pharmacy to ensure medications were added to the eMAR. -He expected MAs not to give medications unless it was on the eMAR. -The consultant pharmacist and the RCC should check for accuracy. -He was not sure how the medication got missed. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. Attempted telephone interview with Resident #5's Urologist on 04/23/25 at 4:58pm was unsuccessful. b. Review of Resident #5's physician's orders dated 09/27/24 revealed there was an order for erythromycin 0.5% ointment (used to treat and prevent certain bacterial eye infections) apply ½ inch ribbon to right eye at bedtime. Review of Resident #5's March 2025 eMAR revealed: -There was an entry for erythromycin 0.5% ointment apply ½ inch ribbon to right eye at bedtime. -Erythromycin 0.5% ointment was documented as administered from 03/01/25 through 03/07/25.	D 358		

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D 358	Continued From page 9 -Erythromycin 0.5% ointment was documented as administered from 03/09/25 through 03/28/25. -Erythromycin 0.5% ointment was documented as administered on 03/30/25 and 03/31/25. -Erythromycin 0.5% ointment was documented as not administered on 03/08/25. -Erythromycin 0.5% ointment was documented as not administered on 03/29/25. Review of Resident #5's April 2025 eMAR revealed: -There was an entry for erythromycin 0.5% ointment apply ½ inch ribbon to right eye at bedtime. -Erythromycin 0.5% ointment was documented as administered from 04/01/25 through 04/05/25. -Erythromycin 0.5% ointment was documented as administered from 04/08/25 through 04/17/25. -Erythromycin 0.5% ointment was documented as administered from 04/19/25 through 04/23/25. -Erythromycin 0.5% ointment was documented as not administered on 04/06/25 and 04/07/25. -Erythromycin 0.5% ointment was documented as not administered on 04/18/25. Observation of Resident #5's medications on hand on 04/23/25 at 1:45pm revealed Erythromycin 0.5% ointment was not available for administration. Interview with a medication aide (MA) on 04/23/25 at 3:02pm revealed: -She had been documenting she gave erythromycin 0.5% ointment to Resident #5 although she did not give it. -She knew she was not supposed to sign off that she gave a medication when she did not give it. -Since Resident #5's medications are filled at another pharmacy, the medications were often confusing so she would sign off she gave it when	D 358		

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D 358	Continued From page 10 she did not give it. -She was unsure of the last time the eye ointment was available for administration. Interview with a second MA on 04/23/25 at 3:10pm revealed: -She thought it had been at least a month or maybe longer since she gave Resident #5 the erythromycin 0.5% ointment. -They run out of his erythromycin 0.5% ointment sometimes since it comes from a different pharmacy and takes awhile to get them back in. -She thought she had signed off that she gave erythromycin 0.5% ointment by accident. -She knew she had not given it at all in the month of April but had signed off she gave it six times. -She was not sure if she had given it in February or March. Interview with the Resident Care Coordinator (RCC) on 04/23/25 at 3:36pm revealed: -Erythromycin 0.5% ointment had not been available for administration for over a month. -The MAs could get in a hurry and forget to order medications or let the RCC know the medications are not available for administration. Interview with the Administrator on 04/23/25 at 3:45pm revealed: -He did not know Resident #5 did not receive his Erythromycin 0.5% ointment. -He expected MAs to contact the pharmacy to get medications and only document it as administered when they administer it. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. Attempted telephone interview with the primary	D 358		

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D 358	Continued From page 11 care provider (PCP) on 04/23/25 at 4:24pm was unsuccessful. The facility's failure to ensure an antibiotic medication used to treat cystitis was administered as ordered for Resident #5, resulting in continued cystitis and elevated lactic acid levels putting Resident #5 at potential risk for becoming septic. This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131-D34 on 04/23/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 7, 2025.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the	D 367	Med Tech's have been advised, too always follow the mar with each medication administration. Med Tech's must compare medication cards with mar to assure accuracy.	4/23/25

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D 367	Continued From page 12 omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure electronic medication administration records (eMARs) were accurate for 1 of 5 sampled residents (Resident #5) related to an antibiotic eye ointment used to treat and prevent certain bacterial eye infections. The findings are: Review of Resident #5's current FL2 dated 09/27/24 revealed diagnoses included unspecified dementia without behavioral disturbance, diabetes type 2, and history of bowel blockages. Review of Resident #5's physician's orders dated 09/27/24 revealed there was an order for erythromycin 0.5% ointment (used to treat and prevent certain bacterial eye infections) apply ½ inch ribbon to right eye at bedtime. Review of Resident #5's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for erythromycin 0.5% ointment apply ½ inch ribbon to right eye at bedtime. -Erythromycin 0.5% ointment was documented as administered from 02/01/25 through 02/28/25.	D 367	Explained to med techs in meeting that mars must be accurate. Med Techs must sign whether OOF, refusals, PA. etc. to assure mar accuracy. RCC will be checking mars weekly for accuracy. Also med techs should do med cart checks weekly.	5/1/25

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	HAL044009	A. BUILDING: _____ B. WING _____	R 04/23/2025

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 367	Continued From page 13 Review of Resident #5's March 2025 eMAR revealed: -There was an entry for erythromycin 0.5% ointment apply ½ inch ribbon to right eye at bedtime. -Erythromycin 0.5% ointment was documented as administered from 03/01/25 through 03/07/25. -Erythromycin 0.5% ointment was documented as administered from 03/09/25 through 03/28/25. -Erythromycin 0.5% ointment was documented as administered on 03/30/25 and 03/31/25. -Erythromycin 0.5% ointment was documented as not administered on 03/08/25. -Erythromycin 0.5% ointment was documented as not administered on 03/29/25. Review of Resident #5's April 2025 eMAR revealed: -There was an entry for erythromycin 0.5% ointment apply ½ inch ribbon to right eye at bedtime. -Erythromycin 0.5% ointment was documented as administered from 04/01/25 through 04/05/25. -Erythromycin 0.5% ointment was documented as administered from 04/08/25 through 04/17/25. -Erythromycin 0.5% ointment was documented as administered from 04/19/25 through 04/23/25. -Erythromycin 0.5% ointment was documented as not administered on 04/06/25 and 04/07/25. -Erythromycin 0.5% ointment was documented as not administered on 04/18/25. Observation of Resident #5's medications on hand on 04/23/25 at 1:45pm revealed Erythromycin 0.5% ointment was not available for administration. Interview with a medication aide (MA) on 04/23/25 at 3:02pm revealed:	D 367		

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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 367	Continued From page 14 -She had been documenting she gave erythromycin 0.5% ointment to Resident #5 although she did not give it. -She knew she was not supposed to sign off that she gave a medication when she did not give it. -She was unsure of the last time the eye ointment was available for administration. -Since Resident #5's medications are filled at another pharmacy, it was often confusing so she would sign off she gave it when she did not give it. Interview with a second MA on 04/23/25 at 3:10pm revealed: -She thought it had been at least a month or maybe longer since she gave Resident #5 the erythromycin 0.5% ointment. -They run out of his medications sometimes since it comes from a different pharmacy and takes awhile to get them back in. -She thought she had signed off that she gave erythromycin 0.5% ointment by accident. -She knew she had not given it at all in the month of April but had signed off she gave it six times. -She was not sure if she had given it in February or March. Interview with the Resident Care Coordinator (RCC) on 04/23/25 at 3:36pm revealed: -Erythromycin 0.5% ointment had not been available for administration for over a month. -MAs would get in a hurry and distracted and sign off even though they did not administer the medication. -They have a facility contracted Registered Nurse (RN) who completes monthly audits and a pharmacist who completes quarterly audits. -It was an oversight. -She tried to check for accuracy weekly, but sometimes it would be biweekly.	D 367	Med Techs were advised to only sign meds out if medication was administered to resident. Also follow mars when giving medication so med tech can be sure that medications are in the cart. Night Shift Med Techs will be auditing med carts weekly.	5/1/25

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 367	Continued From page 15 -It was her responsibility to check for MAR accuracy. Interview with the Administrator on 04/23/25 at 3:45pm revealed: -The RCC tried to check for accuracy on MARS and cart audits weekly. -They also had a pharmacist completing quarterly audits. -MAs possibly get in a hurry and document medications were given by accident if they did not actually give them. -He expected MAs to document medications as administered when they administered them. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. Attempted telephone interview with the primary care provider (PCP) on 04/23/25 at 4:24pm was unsuccessful.	D 367		