	-	ID HUMAN SERVICES			FO	RM APPROVE
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		345411	B. WING			C 1 <b>0/17/2019</b>
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	0/11/2013
HAYWOOD	D NURSING AND REHAE	BILITATION CENTER		516 WALL 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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	through 10/17/19. On	vas conducted on 10/16/19 e of the four allegations was ed. Event ID #J76F11.				
F 755 SS=D	Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)	cedures/Pharmacist/Records (1)-(3)	F 755	;		11/5/19
	§483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.					
	pharmaceutical servic that assure the accur dispensing, and admi	es. A facility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and ne needs of each resident.				
		onsultation. The facility n the services of a licensed				
	§483.45(b)(1) Provide aspects of the provisi the facility.	es consultation on all on of pharmacy services in				
		shes a system of records of n of all controlled drugs in able an accurate				
		ines that drug records are in ount of all controlled drugs riodically reconciled.				

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/19/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION				CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345411	B. WING		10/17/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • • • • • •
HAYWOOI	D NURSING AND REHA	BILITATION CENTER		16 WALL STREET VAYNESVILLE, 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 755	Continued From page	e 1	F 755		
		「 is not met as evidenced			
	Based on record rev pharmacy and physic failed to obtain intrav from an outside phan Residents (Resident	ian interview the facility enous antibiotics (IVABs) macy provider for 1 of 3		1) The plan of correcting the spect deficiency. The plan should address processes that lead to the deficiency cited: On 9/15/19 resident #1 was transferred to the hospital for an evaluation of AMS. On 9/16/19 a medication variance report was con	s the ;y
	Findings included: Resident #1 was admitted to the facility on 9/14/19 at 9:00pm with a diagnoses that included urinary tract infection (UTI), neuromuscular dysfunction of bladder, urinary retention and hypertension. Resident #1 was discharged from the facility on 9/15/19 and then readmitted to the facility on 9/18/19.			on resident #1 for the doses missed the Director of Nursing. The nurses involved received 1:1 education on medication availability process by th Assistant Director of Nursing. On 9/ and 9/24/19 medication doses were per MD order for resident #1 until available from pharmacy. All licens nurses will receive re-education on	d by IV ne (20/19 e held sed
	9/18/19 revealed the intact and required exactivities of daily livin			<ul><li>medication availability process by the Director of Nursing or the Assistant Director of Nursing.</li><li>2) The procedure for implementing acceptable plan of correction for the plan of correction for th</li></ul>	g the
	9/14/19 revealed Res infection (UTI) with se	scharge summary dated sident #1 had a Urinary tract epsis. Resident #1 was 'n 3.375 grams (antibiotic) 8 hours for 14 days.		deficiency cited: An audit was cond on 10/16/19 by the Director of Nurs and the Assistant Director of Nursin residents receiving IV medication to ensure no other residents were affe No others residents were identified	ing ig on cted.
	revealed Resident #1 via stretcher with a so at 10:00pm. The adr	nurse's note dated 9/14/19 was admitted to the facility cheduled dose of Zosyn due nission note further stated out it was unable to be prescribed.		having been affected. In-service education on IV medication available licensed nurses on or before Nover 2019 conducted by the Director of N and the Assistant Director of Nursin Director of Nursing corresponded w pharmacy to have common dosage	ility to nber 5, Nursing g. ⁄ith
	written by the DON re	nce report dated 9/14/19 evealed Resident #1 was y after 5:00pm on Saturday		Zosyn available in Omnicell, change completed 10/14/19. 3) The monitoring procedure to en	e

Facility ID: 923009

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/19/201 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345411	B. WING		10/17/2019
NAME OF PF	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP C	
	NURSING AND REHAE			516 WALL STREET	
HAIWOOL	NORSING AND REHAL			WAYNESVILLE, NC 28786	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 755	Continued From page	e 2 bital with orders for Zosyn	F 75	55 the acceptable plan of corr	ection is
		heduled dose at 10:00pm		effective and that the speci	
	-	19 did not arrive from the		cited remains corrected and	-
		he 6:00 am dose on 9/15/19.		compliance with the regula	
		hat a decision was made to the emergency room due to		compliance: The Director of and/or Assistant Director of	•
		sion. The note further stated		audit 5 times per week for	5
		formulate the correct dose		weekly for 8 weeks on avai	
	Zosyn from the availa	able medication in the facility.		medication to ensure comp	
	Review of Grievance	form dated 9/15/19 revealed		achieved and maintained. Nursing will review the wee	
		wo doses of IV antibiotics		report findings of the audits	-
	(Zosyn) upon return f	rom the hospital. The		QAPI committee monthly x	
		y revealed medications		4) The title of the person	
	were received from pl	-		implementing the acceptab correction: The Director of	
	availability.	eted regarding medication		responsible for the implementation of acceptable plan of correction	entation of the
		r 2019 medication (MAR) revealed Resident as held on 9/20/19 at 10pm.		5) Date when corrective a completed: 11/5/ 2019.	
	Nursing note dated 9/ #1's Zosyn was held of medication on hand.	/20/19 indicated Resident due to not having the			
	was received from the Resident #1's missed	/20/2019 revealed an order e physician to administer l dose of Zosyn held on ith Resident #1's next dose at 6:00am.			
		r 2019 medication (MAR) revealed Resident as held 9/24/19 at 6:00am.			
	-	/24/19 revealed Resident until the new supply arrived			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							<i>I</i> APPROVED 0. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í			(X3) DATE SURVEY COMPLETED		
		345411	B. WING				C 17/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
наумоо	D NURSING AND REHAE			5	516 WALL STREET			
				V	WAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 755	Continued From page	23	F	755				
	<ul> <li>Continued From page 3</li> <li>Interview with pharmacy representative on 10/16/19 at 4:02pm revealed the pharmacy received orders from the facility through fax and telephone and electronic means. She stated in the instance a resident required medication following cut off pharmacy hours of 5:00pm on Saturday the facility should contact the pharmacy. If the facility required a STAT order after hours, it would come from the back up pharmacy. The pharmacy representative further stated the backup pharmacy would not normally have an IV antibiotic medication available.</li> <li>Interview with physician on 10/16/19 at 4:12pm reveled he recalled the incident involving Resident #1's antibiotic not being available upon admission. He indicated the issue was discussed during a facilities Quality Assurance (QA) meeting regarding medication not being available when residents are admitted when certain mediations may not be available for delivery after hours. The</li> </ul>							
	staff were to receive to instance it was an uni- nurse should request send the next does w physician stated in the would not provide the should have been pos- when the medication A continued interview representative on 10/ Pharmacy timeline ins to be placed 3-5 days orders were received	e instance the hospital medication the admission stponed until the next day could be obtained. with the pharmacy 17/19 at 10:17am revealed structions requested orders before running out. If						

Facility ID: 923009

If continuation sheet Page 4 of 8

OLIVIER	S FOR MEDICARE &				OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
					С	
		345411	B. WING		10/17/2019	
NAME OF PF	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		
AYWOOD NURSING AND REHABILITATION CENTER			WALL STREET YNESVILLE, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 755	Continued From pag	e 4	F 755			
	Interview with Reside	opt #1 op 10/17/10 ot				
		ent #1 on 10/17/19 at				
		the night she was admitted.				
		e assumed the issue was				
	resolved.					
	Interview with the Dir	ector of Nursing (DON) on				
		revealed she was aware of				
	the antibiotic Zyson w					
		mission. Resident #1 was				
		t of time for deliveries from y. She stated Resident #1				
		e of the Antibiotic on 9/14/19				
	and 9/15/19. She fur	ther revealed Resident #1				
		e Hospital the morning of				
	9/15/19 and received					
	hospitalized. She sta	rn in QA meeting with				
	members of manage					
	physician in an attern	pt to ensure medications				
		admission. Following a				
		1s September MAR the DON medications were held on				
		19 due to the medications not				
	being delivered at the	e time of Resident #1 next				
		ated residents should have				
	medications on hand scheduled to be adm	-				
F 760		of Significant Med Errors	F 760		11/5/19	
SS=D	CFR(s): 483.45(f)(2)		1 100		11/0/10	
	The facility must ens	ure that its-				
	-	nts are free of any significant				
	medication errors.					
	This REQUIREMEN	T is not met as evidenced				
	by:					

Facility ID: 923009

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/19/201 MAPPROVE 0. 0938-039	
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345411	B. WING				C / <b>17/2019</b>	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
HAYWOOD NURSING AND REHABILITATION CENTER				16 WALL STREET				
				W	AYNESVILLE, NC 28786		1	
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 760	Continued From page	<u>- 5</u>	<b></b>	760				
1 /00				100	deficiency. The plan should address	the		
		ne facility failed to administer nous antibiotics (IVABs) as			deficiency. The plan should address processes that lead to the deficiency			
		sidents (Resident #1).			cited: On 9/15/19 resident #1 was			
					transferred to the hospital for an			
	Findings included:				evaluation of AMS. On 9/16/19 a			
					medication variance report was com			
		nitted to the facility on			on resident #1 for the doses missed			
		th a diagnosis that included			Director of Nursing. The nurses invol			
		(UTI), neuromuscular er, urinary retention and			received 1:1 education on IV medica availability process. On 9/20/19 and	tion		
		ent #1 was discharged from			9/24/19 medication doses were held	ner		
		and then readmitted to the			MD order for resident #1 until availab	•		
	facility on 9/18/19.				from pharmacy. All licensed nurses	will		
					receive re-education on IV medication			
		Set (MDS) assessment dated			availability process by the Director of			
		Resident #1 was cognitively			Nursing or Assistant Director of Nurs			
	activities of daily livin	xtensive assistance with			2) The procedure for implementing acceptable plan of correction for the	the		
		g (ADE S).			deficiency cited: An audit was condu	cted		
	Review of hospital di	scharge summary dated			on 10/16/19 by the Director of Nursir			
	-	sident #1 had a Urinary tract			and the Assistant Director of Nursing	-		
	infection (UTI) with se	epsis. Resident #1 was			residents receiving IV medication to			
		n 3.375 grams (antibiotic)			ensure no other residents were affect			
	intravenously every 8	hours for 14 days.			No others residents were identified a	S		
	Doviou of admission	purps dated 0/14/10			having been affected. In-service	tu to		
	Review of admission revealed Resident #1	was admitted to the facility			education on IV medication availabili licensed nurses on or before Novem	•		
		cheduled dose of Zosyn due			2019 conducted by the Director of N			
		nission note further stated			and the Assistant Director of Nursing			
		at the facility but it was			Director of Nursing corresponded wit			
	unable to be titrated t	for the dose prescribed.			pharmacy to have common dosage of	of IV		
					Zosyn available in Omnicell, change			
		form dated 9/15/19 revealed			completed 10/14/19.			
		wo doses of IV antibiotics			<ol> <li>The monitoring procedure to ensitive acceptable plan of correction is</li> </ol>	sure		
		from the hospital. The ry revealed medications			effective and that the specific deficie	ncv		
	were received from p				cited remains corrected and /or in	icy		
	-	leted regarding medication			compliance with the regulatory			
	availability.				compliance: The Director of Nursing			

Facility ID: 923009

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STATEMENT (	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	```	E CONSTRUCTION	(X3) DA	NO. 0938-039
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			MPLETED
		345411	B. WING	1	C 0/17/2019	
NAME OF P	IAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0.11.2010
HAYWOOD NURSING AND REHABILITATION CENTER			516 WALL STREET WAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 760	Continued From page	e 6	F 76			
	<ul> <li>#1's Zosyn was held</li> <li>Nursing note dated 9</li> <li>#1's Zosyn was held medication on hand.</li> <li>Nursing note dated 9</li> <li>was received from th Resident #1's missed</li> <li>9/20/19 concurrent w of Zosyn on 9/21/19 a</li> <li>Review of Septembe administration record</li> <li>#1's dose of Zosyn w</li> <li>Nursing note dated 9</li> <li>#1's Zosyn was held from pharmacy.</li> <li>Interview with physic reveled he recalled th Resident #1's antibio admission. He indica during a facilities Qua regarding medication residents are admittee may not be available physician stated med prescribed.</li> <li>Interview with Reside 11:15am revealed sh having her antibiotic</li> </ul>	I (MAR) revealed Resident on 9/20/19 at 10pm. /20/19 indicated Resident due to not having the //20/2019 revealed an order e physician to administer d dose of Zosyn held on rith Resident #1's next dose at 6:00am. r 2019 medication I (MAR) revealed Resident vas held 9/24/19 at 6:00am. //24/19 revealed Resident until the new supply arrived ian on 10/16/19 at 4:12pm		<ul> <li>and/or Assistant Director of Nur audit 5 times per week for 4 we weekly for 8 weeks on availabili medication to ensure there is m available for the residents to en compliance is achieved and ma The Director of Nursing will revi weekly audits, and report finding audits monthly to the QAPI com monthly x 3 months.</li> <li>4) The title of the person resp implementing the acceptable pla correction: The Director of Nurs responsible for the implementat acceptable plan of correction.</li> <li>5) Dates when corrective action completed: 11/5/2019.</li> </ul>	eks then ty of IV edication sure intained. ew the gs of the mittee onsible for an of ing will be ion of the	

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/19/2019 APPROVED D: 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
	345411		B. WING			-		C 17/2019
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
науwоо	D NURSING AND REHAE	BILITATION CENTER		-	16 WALL STREET VAYNESVILLE, NC 2878	86		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 760	10/17/19 at 12:00pm the antibiotic Zyson w Resident #1 upon add admitted after the cut the outside pharmacy did not receive 1 dose and 9/15/19. She fur was discharged to the 9/15/19 and received hospitalized. She sta discussed the concer members of manager physician in an attem were available upon a review of Resident #1's 10/20/19 and 10/24/1 being delivered at the	ector of Nursing (DON) on revealed she was aware of vas not available for mission. Resident #1 was of time for deliveries from v. She stated Resident #1 e of the Antibiotic on 9/14/19 ther revealed Resident #1 e Hospital the morning of her Antibiotics while ted the facility had n in QA meeting with ment and the facility pt to ensure medications admission. Following a Is September MAR the DON medications were held on 9 due to the medications not e time of Resident #1 next ated residents should have at the time they were	F	760				

Facility ID: 923009

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