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-C 07/20/2023

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 and follow up survey and a complaint investigation on 07/19/23 to 07/20/23.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to protect 1of 5 sampled residents (Resident #3) from neglect by not repairing or replacing a broken wheelchair that caused pain of the shoulder, hip, and knee and failed to offer medication treatment for shoulder, hip, and knee pain caused by the broken wheelchair for 1 year. The findings are: Review of Resident #3's current FL-2 dated 07/06/23 revealed: -Diagnoses included cerebral palsy, paresis lower extremity, hip pain, knee pain, and minor memory loss. -Resident was non-ambulatory and required the assistance of a wheelchair and transfer equipment. Review of Resident #3's Care Plan dated 09/21/22 revealed: -Resident #3 required daily assistance with	D 338		

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-C 07/20/2023

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 338	Continued From page 1	D 338		

transfers, grooming, dressing, ambulation, toileting, and eating.
-He was forgetful and needed reminders.

Review of Resident #3's House Standing Orders dated 09/12/18 revealed acetaminophen (pain reliever) tablets were listed as a standing order.

Review of Resident #3's electronic medication administration record (eMAR) for 05/01/23-07/19/23 revealed:
-There was no entry for acetaminophen 325mg every 4 hours.
-There was no documentation acetaminophen 325mg was administered from 05/01/23 through 07/19/23.

Review of Resident #3's Mobility Clinic referral form completed by Physical Therapy (PT) dated 06/07/23 revealed:
-The Resident Care Coordinator (RCC) was listed as the contact person with name and email address.
-The facility's contracted Nurse Practitioner (NP) was listed with name and phone number.
-The reason for the referral was listed as "shoulder pain propelling wheelchair, weight gain, increased difficulty with transfers."
-Diagnoses listed was cerebral palsy since birth and lower extremity paresis.
-Resident #3's experienced pain in his hips, knees, and shoulders.
-Resident #3's ambulation status was documentated as "none, even with the assistance of others or devices".
-Problems with the current wheelchair were documented as "shoulder pain, hip/knee discomfort, ineffective brakes, broken armrest, difficult to propel".
-Amount of hours the resident spent in the

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-C 07/20/2023

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 338	Continued From page 2	D 338		

wheelchair was documented as 15 hours daily.
-Resident #3's comfort level documented was "uncomfortable as wheelchair is difficult to propel and hurts lower back to sit in chair".
-Resident #3 required 2-3 staff people with transfers to and from the wheelchair.

Interview with PT on 07/19/23 at 3:00pm revealed:
-The wheelchair was a generic wheelchair which was not intended for daily use.
-The resident had been experiencing shoulder pain.
-He worked with the resident 2 times weekly for treatment of upper extremity strength and transfer strength.
-The wheelchair was missing an armrest and the brakes did not work properly.

Interview with Personal Care Aide (PCA) on 07/19/23 at 3:48pm revealed:
-Resident #3 required 2-3 staff for dressing, bathing, and transfers.
-Resident #3 was able to self-propel his wheelchair.
-She thought the resident needed a new wheelchair for about 2-3 months, but was not sure.

Interview with a second PCA on 07/19/23 at 4:00pm revealed:
-Bathing and transferring Resident #3 required 2-3 staff.
-Resident #3 could communicate with staff and express pain.

Interview with a MA on 07/19/23 at 4:05pm revealed:
-The resident was unable to assist with transfers and required the assistance of 2-3 staff.

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-C 07/20/2023

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 338	Continued From page 3	D 338		

-A staff person would have to stand behind the wheelchair to prevent the wheelchair from rolling away during transfers because the brakes did not work properly.
-She thought the resident needed a new wheelchair for about 6 months.
-The wheelchair was too small for the resident and squeezed his hips, limiting his movement.

Observations of Resident #3's wheelchair on 07/20/23 at 8:05am revealed:
-One armrest pad was missing, and a thin metal bar was visable where the armrest pad should be.
-When the brakes were in the locked position the wheelchair still rolled.
-One front wheel had no rubber left, exposing a white plastic rim.

Interview with the PT Supervisor on 07/20/23 at 8:27am revealed:
-Resident #3 needed a new wheelchair for a year.
-Around 01/01/23 Resident #3 reported his shoulder pain to her.
-She had been speaking with the RCC and NP about the resident's need for a new wheelchair, the resident's shoulder pain, and difficulty with the wheelchar for almost 3 months.
-The facility should have obtained Resident #3 a new generic wheelchair as the process was long to get custom fitted wheelchairs.
-Over the course of a year, the resident experienced an increase in pain and a decrease in physical ability due to the current wheelchair.
-The Resident could pull himself up with his transfer equipment, but he could no longer do this due to the pain in his shoulders.
-The Resident needed a supportive wheelchair for ease of movement and reduction of joint pain.

Interview with a third PCA on 07/20/23 at

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-C 07/20/2023

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 338	Continued From page 4	D 338		

10:15am revealed the resident's wheelchair used to have a bath towel wrapped around the metal arm of the wheelchair.

Interview with a second MA on 07/20/23 at 10:20am revealed:
-She did not know how long the resident's wheelchair had been broken.
-She knew the brakes did not work properly, but did not tell anyone.
-The resident would tell her that his hands hurt from propelling himself in the wheelchair, and she would give him a bandage.
-She never gave him medication for pain relief.

Interview with facility's contracted NP on 07/20/23 at 11:46am revealed:
-Resident #3 received PT since admission to the facility.
-She saw Resident #3 within the past week but did not know if the resident needed a wheelchair as she was not a "good judge of equipment".
-She heard discussions of getting the resident a specialized wheelchair during team meetings with the RCC and PT.
-Resident #3 had osteoarthritis (inflammation of the joint) in his shoulders, hips, and knees.
-She discussed the resident's pain in team meetings and had not intervened in the facility's treatment of his pain.
-She thought the resident would always be in pain and did not think pain medication was needed.
-No one told her about the resident's increased shoulder pain.
-She did not agree with PT's evaluation of the resident.

Interview with RCC on 07/20/23 at 12:03pm revealed:
-She was aware Resident #3's wheelchair was in

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-C 07/20/2023

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 338	Continued From page 5	D 338		

very poor condition.
-She tried to order a new wheelchair about a year ago and was unsuccessful because Medicaid denied the cost of a new wheelchair as not enough time had elapsed since the previous wheelchair was purchased.
-No one suggested getting a temporary wheelchair while the referral was being completed for the custom wheelchair.
-Staff should have told her that the resident's wheelchair was broken.
-The facility had not made any efforts to replace the old wheelchair or administer pain medication.
-She did not know why the resident was never given medication for his pain.
-Today was the first time that she read the PT referral.
-Staff should have told her that the resident was in pain.
-She did not remember having a discussion with PT about his need for a new wheelchair or his need for pain medication.

Interview with the Administrator on 07/20/23 at 2:05pm revealed:
-It was the facility's responsibility to correct any problem.
-He doubted that staff reported the resident's pain to the RCC.
-He did not want the resident to be in pain.
-He tried to get a new wheelchair for the resident about a year ago and was unsuccessful as Medicaid would not pay for a new wheelchair.
-Someone should have fixed the armrest of the wheelchair.

Attempted telephone interview with Resident #3's family member on 07/20/23 at 11:10am and 12:03pm was unsuccessful.

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-C 07/20/2023

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 338	Continued From page 6 Based on interviews and record reviews, it was determined that Resident #3 was not interviewable. _____ The facility failed to ensure Resident #3 was free from neglect related to not replacing a broken wheelchair after receiving reports of and observing the wheelchair was in disrepair over the course of one year, causing pain and discomfort in his shoulders, hips, and knees which was not treated by the facility resulting in loss of previous ability to stand and increased pain of the shoulders, hips, and knees. This failure resulted in serious neglect of the resident and constitutes a Type A1 violation. _____ The facility provided a plan of protection on 07/20/23 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 19, 2023.	D 338		
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 interviews and record reviews, the	D 451		

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-C 07/20/2023

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 451	Continued From page 7	D 451		

facility failed to notify the local county Department of Social Services (DSS) for incidents involving 2 of 3 sampled residents (Resident #1 and #5) who received injuries that required emergency medical treatment.

The findings are:

1. Review of Resident #1's current FL2 dated 06/02/23 revealed:
-Diagnoses included hypertension.
-Resident #1 was ambulatory.
-There was an order for Plavix 75mg once daily.

Review of the Resident Register for Resident #1 revealed an admission date of 06/02/23 .

Review of Emergency Department (ED) discharge instructions dated 07/18/23 revealed Resident #1 was evaluated for a fall with a laceration to the forehead and brain hemotoma.

Review of an Accident/Incident Report for Resident #1 dated 07/09/23 revealed:
-On 07/09/23 at 6:20am Resident #1 was found in her room on the floor, a knot on her forehead, bleeding and a skin tear to the left arm.
-Resident #1 had was currently taking Plavix (blood thinner) and was transported to a local hospital by Emergency Medical Services (EMS) on 07/09/23 at 6:30am.
-The primary care physician and responsible person were notified.
-There was no documentation the local county Department of Social Services (DSS) had been notified.

Review of the progress notes for Resident #1 dated 06/09/23-06/19/23 revealed there was no documentation that the local county DSS had

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-C 07/20/2023

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 451	Continued From page 8	D 451		

been notified.

Interview with the Resident Care Coordinator (RCC) on 07/20/23 at 1:00pm revealed:
-She was responsible for faxing the Accident/Incident Report for all residents in the facility including Resident #1 to the local DSS.
-She had not faxed the incident report to the local county DSS.
-She did not know why she had not faxed the documentation to the local DSS.

Interview with the local county DSS Adult Home Specialist on 07/19/23 at 10:35am revealed she had not been notified of Resident #1's 07/09/23 accident that required emergency treatment at the local hospital.

Interview with a medication aide (MA) on 07/19/23 at 9:10am revealed:
-He was on duty 07/09/23 when Resident #1 had sustained the knot to her forehead.
-He had notified Resident #1's family and the on-call provider.
-He did not notify DSS and did not know who was responsible for notifying DSS.

Refer to interview with the Administrator on 07/20/23 at 2:00pm.

2. Review of Resident #5's current FL2 dated 10/18/22 revealed:
-Diagnosis included osteoarthritis.
-Resident #5 was ambulatory with a walker.

Review of Resident #5's Resident Register dated 10/28/19 revealed an admission date of 10/28/19.

a. Review of Resident #5's radiology report from the facility's contracted diagnostic company dated

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-C 07/20/2023

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 451	Continued From page 9 07/10/23 revealed an x-ray of the right knee was obtained after a fall and Resident #5 had an acute right fibular neck (the smaller bone of the lower leg located at the knee) fracture. Review of Resident #5's Incident and Accident Report dated 07/10/23 revealed: -Resident #5 fell in the shower landing on his right knee. -Resident #5 did not complain of pain and there was documentation Resident #5 had swelling and redness of the right knee. -There was documentation Resident #5 was transported to the local hospital emergency department (ED) after an x-ray of the right knee was completed. -Resident #5's primary care provider (PCP) and family member were notified of the fall. -There was no documentation the local county Department of Social Services (DSS) was notified. Review of Resident #5's progress notes dated 07/10/23 revealed: -At 10:10am, there was documentation Resident #5 fell getting into the shower on his right knee and had no complaints of pain but did have swelling and redness and an x-ray was ordered. -At 3:20pm, there was documentation an x-ray was completed for Resident #5, and he had a fracture in the knee. -At 3:52pm, there was documentation Resident #5 was transported to the local hospital ER. -At 11:00pm, there was documentation Resident #5 returned to the facility with ER discharge instructions and there was no evidence of a right knee fracture. -There was no documentation Resident #5's Incident and Accident Report was faxed to the local DSS.	D 451		

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-C 07/20/2023

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 451	Continued From page 10 Interview with a medication aide (MA) on 07/20/23 at 9:37am revealed: -She was on duty on 07/10/23 when Resident #5 fell in the shower and landed on his right knee. -She notified Resident #5's PCP of the fall and the swelling of the right knee and the PCP ordered an x-ray. -Resident #5's x-ray report showed a fracture in the right knee and the PCP ordered to send Resident #5 to the local hospital ER for an evaluation. -She filled out an Incident and Accident Report for Resident #5's fall and gave the report to the Resident Care Coordinator (RCC). -The RCC was responsible to fax Incident and Accident Reports to the local DSS. Interview with the local county DSS Adult Home Specialist (AHS) on 07/20/23 at 10:48am revealed she did not receive an Incident and Accident Report from the facility for Resident #5's fall occurring on 07/10/23 requiring an emergency medical evaluation and medical treatment other than first aid. Interview with the RCC on 07/20/23 at 12:04pm revealed: -She was responsible for faxing Incident and Accident Reports to the local DSS. -She did not fax Resident #5's Incident Report dated 07/10/23 to the local DSS. -She did not know why she did not fax Resident #5's Incident and Accident Report to the local DSS. Refer to the interview with the Administrator on 07/20/23 at 2:00pm. b. Review of Resident #5's Incident and Accident	D 451		

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-C 07/20/2023

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 451	Continued From page 11	D 451		

Report dated 07/12/23 revealed:
-Resident #5 fell in the bathroom at 2:30pm and there was documentation Resident #5 did not sustain any injuries.
-Resident #5's primary care provider (PCP) and family member were notified.
-There was documentation that first aid was not required and was not sent to the local hospital emergency room (ER) for a medical evaluation.
-There was no documentation Resident #5's Incident and Accident Report dated 07/12/23 was faxed to the local county DSS.

Review of Resident #5's progress notes dated 07/12/23 at 2:35pm revealed:
-Resident #5 fell in the bathroom and there was documentation he was not hurt.
-Resident #5's family member requested Resident #5 be taken to the local orthopedic office for a medical evaluation.

Review of Resident #5's orthopedic referral note dated 07/13/23 revealed:
-Resident #5 had a compression fracture of the lumber spine (collapsed vertebra in the lower spine).
-Resident #5 had a fibula (the smaller bone of the lower leg located at the knee) fracture.

Interview with the local county DSS Adult Home Specialist (AHS) on 07/20/23 at 10:48am revealed she did not receive an Incident and Accident Report from the facility for Resident #5's fall occurring on 07/12/23 requiring an evaluation and medical treatment other than first aid.

Interview with the RCC on 07/20/23 at 12:04pm revealed:
-She was responsible for faxing Incident and Accident Reports to the local DSS.

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-C 07/20/2023

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 451	Continued From page 12 -She did not fax Resident #5's Incident Report dated 07/12/23 to the local DSS. -She did not know why she did not fax Resident #5's Incident and Accident Report to the local DSS. Refer to the interview with the Administrator on 07/20/23 at 2:00pm. _____ Interview with the Administrator on 07/20/23 at 2:00pm revealed: -The RCC was responsible for faxing Accident and Incident reports to DSS. -The RCC missed faxing two or three reports.	D 451		