	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING		COMPLETED
		345478	B. WING		07/23/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
HARNETT	WOODS NURSING AND	REHABILITATION CENTER		04 LUCAS ROAD DUNN, NC 28334	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETIC
E 000	Initial Comments		E 000		
	was conducted on 7/2 facility was found to b CFR §483.73 related Subpart-B-Requireme Facilities. Event ID#	ents for Long Term Care 2QW311			
F 000	INITIAL COMMENTS	i	F 000		
	Control Survey was of 7/23/22. The facility	OVID-19 Focused Infection conducted on 7/22/22 and was found to be out of CFR §483.80 infection control			
F 880 SS=E	Infection Prevention a CFR(s): 483.80(a)(1)		F 880		8/26/22
	infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable			
	program. The facility must esta	prevention and control blish an infection prevention (IPCP) that must include, at ving elements:			
	reporting, investigatin and communicable d	em for preventing, identifying, ng, and controlling infections iseases for all residents, ors, and other individuals der a contractual			

Electronically Signed

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.

08/08/2022

						IO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	E SURVEY IPLETED	
		345478	B. WING		07/23/2022		
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
HARNETT	WOODS NURSING AND	REHABILITATION CENTER		304 LUCAS ROAD DUNN, NC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 880	Continued From page	e 1	F 880				
		to §483.70(e) and following					
	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:						
	 (i) A system of surveil possible communicat infections before they persons in the facility 	can spread to other					
	(ii) When and to whor	, n possible incidents of se or infections should be					
	(iii) Standard and tran to be followed to prev	nsmission-based precautions rent spread of infections; plation should be used for a					
	resident; including bu (A) The type and dura	t not limited to:					
	involved, and (B) A requirement that	t the isolation should be the ble for the resident under the					
	circumstances. (v) The circumstance	s under which the facility ees with a communicable					
	contact with residents contact will transmit the	kin lesions from direct or their food, if direct he disease; and procedures to be followed					
	by staff involved in di						
	§483.80(a)(4) A syste identified under the fa corrective actions tak						
	§483.80(e) Linens. Personnel must hand	le, store, process, and					

If continuation sheet Page 2 of 18

		MEDICAID SERVICES			OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED	
		345478	B. WING		07/23/2022	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HARNETT	WOODS NURSING AND	REHABILITATION CENTER	604 LUCAS ROAD DUNN, NC 28334			
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETI	
F 880	Continued From page	e 2	F 880			
	IPCP and update the This REQUIREMENT by: Based on observatio interview, and physic failed to update their transmission-based p prevention and therel (Resident # 1, #7, and residents reviewed for transmission-based p during a coronavirus The findings included The facility's policy er Quarantine Consider	act an annual review of its ir program, as necessary. is not met as evidenced n, record review, staff ian interview the facility policy regarding precautions for COVID-19 by failed to place three d #9) out of eight sampled or COVID-19 prevention on precautions. This occurred pandemic. I.		Harnett Woods Nursing and Rehabilitation Center acknowledge receipt of the Statement of Deficie and proposes this Plan of Correcti the extent that the summary of find factually correct and in order to ma compliance with applicable rules a provisions of quality of care of resi The Plan of Correction is submitte written allegation of compliance. Harnett Woods Nursing and Rehal Center response to this Statement	ncies on to dings is aintain ind dents. d as a bilitation t of	
	10/8/21, read in part, vaccinated that leave hours or who have cle COVID-19 positive in require quarantine. H must: wear a mask, s two days after expose after exposure to con	dividual in the facility, do not owever, these residents cocially distance, be tested ure and again at 5-7 days firm they are negative."		Deficiencies does not denote agre with the Statement of Deficiencies does it constitute an admission that deficiency is accurate. Further, Ha Woods Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Disp Resolution, formal appeal procedur and/or any other administrative or	nor at any rnett Center the pute ire	
	guidance revealed Cl updated again on 2/2 facility's last policy up guidelines read in par "Roommates of resid infection should be m	ter for Disease Control) DC's guidelines had been /22; which was after the odate. The 2/2/22 CDC rt as follows: ents with SARS-CoV-2 lanaged as described in sidents who have had Close		proceeding. F880 Infection Prevention & Contr On 8/1/2022 resident #1 complete required transmission-based preca for COVID 19 infections, on 7/15/2	d autions	

Facility ID: 924467

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		MEDICAID SERVICES				O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	. ,	E SURVEY IPLETED
		345478	B. WING		0.	7/23/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	, ZIP CODE	
HARNETT	WOODS NURSING ANI	D REHABILITATION CENTER		604 LUCAS ROAD DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 880	Continued From pag	e 3	F 88			
	Infection."			transmission-based pr	recautions for	
				COVID 19 infections,		
	Empiric use of Trans	smission-Based Precautions		resident # 9 completed	d required	
		nmended for residents who		transmission-based pr	recautions for	
	-	o the facility and for residents		COVID 19 infections.		
		contact with someone with			:	
		on if they are not up to date d COVID-19 vaccine doses."		On 7/22/2022 the facil initiated 100% audit of	-	
		d COVID-19 vaccine doses.		residents COVID vac		
	"In general, all reside	ents who are not up to date		audit was to identify a		
	-	d COVID-19 vaccine doses		date on COVID vaccin		
		ions and readmissions		Director of nursing, un	it managers and	
	should be placed in o	quarantine, even if they have		infection preventionist	addressed all	
		admission, and should be		concerns identified du		
		in the testing section;		include assessing the		
		counties with low community		vaccine/booster per re		
	approach for determi	lect to use a risk-based		and initiating transmis precautions for all resi		
		arantine upon admission."		up to date on COVID		
				and who had closed c		
	Review of CDC's CC	VID transmission rates for		someone with SAR-Co		
	the facility's county re	evealed for all the dates on				
	which data was reco	rded between 6/15/22 and		On 7/26/22, the corpo		
		transmission rate was		reviewed the CDC rec		
	marked as high.			transmission-based pr		
	On 7/22/22 a rayiou	of the facility's COVID accor		residents who have ha		
		of the facility's COVID case revealed the facility was		someone with SAR-Co updated the facility gu		
	-	status. As of 7/22/22 one		recommendations. The	-	
	-	d COVID and was on TBP		for Quarantine Consid		
	-	precautions). As of 7/22/22		Community Visits and		
		rrently was out of work due		initiated and reviewed	-	
	U	COVID. The facility's		Administrator via telec		
		ed they had been using		include the requirement		
		g the outbreak to identify		transmission based pr		
	high risk exposures.			resident who were not COVID vaccine/booste	-	
	1a Resident # 9 was	s admitted to the facility on		closed contact with so		
		cumentation provided by the		SAR-CoV-2 infection.		

Facility ID: 924467

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	. ,	E SURVEY PLETED
		345478	B. WING		07	/23/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
HARNETT	WOODS NURSING AND	REHABILITATION CENTER		604 LUCAS ROAD DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 880	Continued From page	e 4	F 88	0		
F 880	facility regarding COV tracking information r fully vaccinated but n vaccinations. Resider reside with Resident 7/1/22. According to the facil positive for COVID or positive for COVID or Resident #9's nursing AM, 7/8/22 at 12:55 F revealed the resident was afebrile, and had non-productive cough COVID. 1b. Resident # 7 was 12/16/21. Review of of the facility regarding tracking information r fully vaccinated but n was documented as a prior to the date of 7/ positive for COVID or positive for COVID or Resident # 7's nursin AM, 7/8/22 at 1:47 PI 7/13/22 at 1:22 PM re shortness of breath a	VID vaccine and case revealed Resident # 9 was of up to date with her COVID ent # 9 was documented to # 8 prior to the date of ity logs, Resident #8 tested in 7/1/22. Resident # 9 tested in 7/4/22. g notes on 7/5/22 at 10:37 PM, and 7/10/22 at 11:05 AM c had non labored breathing, d an occasional in after being diagnosed with s originally admitted on documentation provided by COVID vaccine and case revealed Resident # 7 was of up to date. Resident # 7 residing with Resident # 6 1/22. Resident # 6 tested in 7/1/22. Resident # 7 tested		On 7/26/22, the Adminis Infection Preventionist ir in-service with all nurses assistants, admission st payable, accounts recei worker, maintenance sta therapy staff, receptionis medical records, and ac regarding the updated G Quarantine Consideratio Visits and Close Contac on providing transmissio precautions for any resid up to date on COVID va and who had closed cor someone with SAR-CoV in-service will be comple After 8/26/2022, any nur assistants, admission st payable, accounts recei worker, maintenance sta therapy staff, receptionis medical records, and ac has not received the in-service scheduled work shift. Al will be in-serviced during regarding Guidelines for Considerations for Com Close Contact.	nitiated an s, nursing saff, accounts vable, social aff, dietary staff, st/screeners, stivities staff Guidelines for ons for Community at with emphasis on based dent who were not accine/boosters ntact with /-2 infection. The eted by 8/26/2022. rses, nursing saff, accounts vable, social aff, dietary staff, st/screeners, stivities staff who service will prior to the next I newly hired staff g orientation r Quarantine	
	to nose."	o only have runny stuffiness		The Unit Managers, Min Nurse (MDS) and Infect will audit all current resid	ion Preventionist dents COVID	
	facility on 6/3/22 and 7/21/22. According to	s originally admitted to the readmitted to the facility on o Resident # 1's record, he for COVID but not up to date.		vaccine status weekly x monthly x 1 month utilizi Immunization/TBP Audit to identify any resident v	ing the t Tool. This audit is	

Facility ID: 924467

CIENCIES ECTION	(X1) PROVIDER/SUPPLIER/CLIA				
	IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE S COMPL	
	345478	B. WING		07/2	23/2022
R OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP (CODE	
DS NURSING AND	REHABILITATION CENTER		604 LUCAS ROAD DUNN. NC 28334		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
inued From page	e 5	F 88	0		
dent # 1 tested n mission to the fa dent # 1 was obs n a room residing e was no signag dent # 1 was on autions. Nurse # room at this time ective equipment ection and a N95 ng Nurse # 1 was ther the resident just returned to was ther the resident just returned to was a and reported the ated their facility pa admissions or re- e not up to date was not up to date was not up to date was hereferenced vac missions did not y had not been ta month and there ted many reside ng roommates of tive for COVID of mate to their root oommate to their root oommate on day rmine if they would a to residents. All	egative for COVID upon cility on 7/21/22. served on 7/22/22 at 10:00 g with another resident. e on the door indicating transmission- based 1 was observed in Resident e without full PPE (personal). Nurse # 1 had eye mask but no gown. Upon s interviewed regarding was on TBP and stated she vork and did not know. s interviewed on 7/23/22 at e following. They had not policy since the CDC ney had not been placing admissions on TBP if they vith COVID vaccines bing by the former guidance ccinated admission/ have to be placed on TBP. king many admissions in the fore this would not have nts. They also had not been f residents who tested n TBP. They did restrict the bom while the facility tested vs 1,2, 3, 5 and 7 to ald contract COVID. All staff, s not in outbreak status, r N95 masks while providing the staff also were required		 COVID vaccines/booster of not up to date on vaccines the facility initiated the app transmission-based precateresident not up to date on and that has had close corsomeone with SAR-CoV-2 Unit Managers, MDS nursel Infection Preventionist will concerns identified during include assessment of the providing vaccination per repreference and initiating approximation to ensure all concernaddressed. The DON will forward the remonstration/TBP Audit To Executive QA Committee wonthly for 2 monthly for 2 monthly for 2 monthly for 1 monthly for 2 monthly for 2 monthly for 2 monthly for 2 monthly for 1 monthly for 2 monthly for	status to ensure propriate utions for any COVID vaccine ntact with infection. The e and/or address all the audit to resident, resident ppropriate utions when Nursing (DON) on/TBP Audit n monthly x 1 rns were results of the col to the ce (QA) nonths. The will meet review the bol to determine may need to place and to	
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I inued From page dent # 1 tested n mission to the fa- dent # 1 was obs n a room residing e was no signag dent # 1 was on autions. Nurse # room at this time ective equipment ection and a N95 ng Nurse # 1 was her the resident just returned to w Administrator wa 1 and reported th ted their facility p tes on 2/2/22. Th admissions or re not up to date w use they were ge h referenced vac missions did not v had not been ta month and there ted many reside ng roommates or ive for COVID or mate to their roo oommate on day rmine if they wou o if the facility was to residents. All ear eye protectio facility was also o heating and air s	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) inued From page 5 dent # 1 tested negative for COVID upon mission to the facility on 7/21/22. dent # 1 was observed on 7/22/22 at 10:00 n a room residing with another resident. e was no signage on the door indicating dent # 1 was on transmission- based autions. Nurse # 1 was observed in Resident room at this time without full PPE (personal ective equipment). Nurse # 1 had eye ection and a N95 mask but no gown. Upon ng Nurse # 1 was interviewed regarding her the resident was on TBP and stated she just returned to work and did not know. Administrator was interviewed on 7/23/22 at 1 and reported the following. They had not ited their facility policy since the CDC tites on 2/2/22. They had not been placing admissions or readmissions on TBP if they enot up to date with COVID vaccines use they were going by the former guidance h referenced vaccinated admission/ missions did not have to be placed on TBP. / had not been taking many admissions in the month and therefore this would not have ted many residents. They also had not been ng roommates of residents who tested ive for COVID on TBP. They did restrict the imate to their room while the facility tested ioommate on days 1,2, 3, 5 and 7 to rmine if they would contract COVID. All staff, if the facility was not in outbreak status, erequired to wear N95 masks while providing to residents. All the staff also were required ear eye protection while caring for residents. facility was also using plasma filters within heating and air system in addition to using lectrostatic sprayer for disinfectant	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG inued From page 5 F 88 dent # 1 tested negative for COVID upon mission to the facility on 7/21/22. F 88 dent # 1 was observed on 7/22/22 at 10:00 n a room residing with another resident. F 88 e was no signage on the door indicating dent # 1 was on transmission- based autions. Nurse # 1 was observed in Resident room at this time without full PPE (personal ective equipment). Nurse # 1 had eye ection and a N95 mask but no gown. Upon g Nurse # 1 was interviewed regarding her the resident was on TBP and stated she just returned to work and did not know. Administrator was interviewed on 7/23/22 at 1 and reported the following. They had not ted their facility policy since the CDC tets on 2/2/22. They had not been placing admissions or readmissions on TBP if they rot up to date with COVID vaccines use they were going by the former guidance h referenced vaccinated admission/ missions did not have to be placed on TBP. r had not been taking many admissions in the month and therefore this would not have ted many residents. They also had not been ng roommates of residents who tested ive for COVID on TBP. They did restrict the immate to their room while the facility tested oommate on days 1,2, 3, 5 and 7 to rmine if they would contract COVID. All staff, if the facility was not in outbreak status, required to wear N95 masks while providing to residents. All the staff also were required aar eye protection while caring for residents. facility was also using plasma filters within heating and air system in addition to using	DUNN, NC 28334SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREVIDERS PLAN OF (EACH ORRECTIVE AC CROSS-REFERENCED TO DEFICIENinued From page 5 dent # 1 tested negative for COVID upon mission to the facility on 7/21/22.F 880inued From page 5 dent # 1 was observed on 7/22/22 at 10:00 n a room residing with another resident. e was no signage on the door indicating dent # 1 was observed in Resident room at this time without full PPE (personal autions. Nurse # 1 was observed in Resident room at his time without full PPE (personal settive equipment). Nurse # 1 had eye tetion and a N95 mask but no gown. Upon ther the resident was on TBP and stated she uust returned to work and did not know.Infection Preventionist will concerns identified during include assessment of the providing vaccination per r preference and initiating a transmission-based preca indicated 1. The Director of 1 will review the Immunization TDP Audit TA transmissions on TBP if they in ot up to date with COVID vaccines use they were going by the former guidance h referenced vaccinated admissions in the month and therefore this would not have ted many residents. They also had not been mins if they would contract COVID. All staff, if the facility was also using plasma filters within heading and air system in addition to usingID ID ID PREVIDE 	SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETIX TAG PROVIDERS FLAN OF CORRECTURATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) inued From page 5 dent # 1 tested negative for COVID upon mission to the facility on 7/21/22. F 880 COVID vaccines/booster or any resident not up to date on vaccine status to ensure the facility initiated the appropriate transmission-based precautions for any resident not up to date on COVID vaccine and that has had close contact with someone with SAR-CoV-2 infection. The Unit Managers, MDS nurse and/or include assessment of the resident, providing vaccination per resident, providing vaccination per resident, providing vaccination per resident, providing vaccination per resident transmission-based precautions when indicated. The Director of Nursing (DON) will review the Immunization/TBP Audit Tool to the Executive QA Committee will meet month and therefore this would not have ted many residents. They also had not been promine if they would contract COVID valcenes use they were going by the former guidance hr referenced vaccinated admission/ missions did not have to be placed on TBP. the and therefore this would not have ted many residents. They also had not been ng roommates of residents, who tested two for COVID or TBP. They did restrict the month and therefore this would not have ted many residents. They also had not been ng roommates of residents, who tested two for COVID or TBP. They did restrict the mate to their solution taks tatus, required to wear NS5 masks while providing to residents. Alt he staff also were required ar eye protection while caring for residents, facility was also using plasma filters within heating and air system in addition to using The DON will forward the results of the Immunization/TBP Audit Tool to the Executive Quality

Facility ID: 924467

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/18/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		345478	B. WING		07/23/2022
NAME OF PI	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CO	•
HARNETT	WOODS NURSING AND	DREHABILITATION CENTER		LUCAS ROAD NN, NC 28334	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 880 F 883 SS=D	the current time of 7/2 one resident who was Administrator reporte had been COVID pos outbreak had been ver hospitalized or expire The facility's Medical 7/23/22 at 1:45 PM a During the facility's cl of the residents had a residents, who had ca the current outbreak, and historically had C boosted their immuni some of the residents TBP, it was his opinic significantly impacted gotten sick. The Med when the outbreak of residents on a prophy Vitamin D, Vitamin C Influenza and Pneum CFR(s): 483.80(d)(1) §483.80(d) Influenza immunizations §483.80(d)(1) Influen policies and procedur (i) Before offering the each resident or the n receives education re potential side effects (ii) Each resident is o immunization Octobe annually, unless the i	d areas to control cases. At 23/22, the facility only had s COVID positive. The ed none of the residents who sitive in the facility's current ery sick. None had been ed from COVID illness. Director was interviewed on nd reported the following. urrent outbreak status, none any severe illness. Some ontracted the illness during had both been vaccinated COVID before. This had ity and therefore even if s had not been placed on on that this had not d the outcome of who had lical Director also stated that ccurred, he had placed all ylactic COVID cocktail of , Zinc, and Pepcid. nococcal Immunizations (2) and pneumococcal iza. The facility must develop res to ensure that- e influenza immunization, resident's representative egarding the benefits and of the immunization;	F 880		8/26/22

Event ID: 2QW311

Facility ID: 924467

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					NETRUCTION		NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		NSTRUCTION	· · ·	ATE SURVEY
		345478	B. WING _				07/23/2022
NAME OF PF	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	E	
HARNETT	WOODS NURSING AND	REHABILITATION CENTER	604 LUCAS ROAD DUNN, NC 28334				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	<	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 883	Continued From page	e 7	F 8	383			
	immunized during thi						
	(iii) The resident or the resident's representative						
		o refuse immunization; and					
	(iv)The resident's me	dical record includes					
	following:	lucates, at a minimum, the					
		or resident's representative					
	· · ·	ion regarding the benefits					
	and potential side eff	ects of influenza					
	immunization; and	- 141					
		either received the influenza					
	immunization due to						
	refusal.						
		nococcal disease. The facility					
		s and procedures to ensure					
	that- (i) Before offering the	nnoumococcal					
		esident or the resident's					
		es education regarding the					
	benefits and potentia	I side effects of the					
	immunization;	6 1					
	(II) Each resident is o immunization, unless	ffered a pneumococcal					
		ated or the resident has					
	already been immuni						
		ne resident's representative					
		o refuse immunization; and					
	(iv)The resident's me	ndicates, at a minimum, the					
	following:						
		or resident's representative					
	-	ion regarding the benefits					
	-	ects of pneumococcal					
	immunization; and (B) That the resident	either received the					
		nization or did not receive					
	prieumococcar immu						

Facility ID: 924467

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		MEDICAID SERVICES					D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			· · ·	E SURVEY PLETED
		345478	B. WING			07	/23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HARNETT	WOODS NURSING AND	REHABILITATION CENTER	604 LUCAS ROAD DUNN, NC 28334		04 LUCAS ROAD DUNN, NC 28334		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETIO
F 883	Continued From page	e 8	F	883			
	the pneumococcal im contraindication or re	nmunization due to medical					
		Γ is not met as evidenced					
	Based on record rev	iew and staff interview the e two (Residents # 4 and #			F883 Influenza and Pneumococcal		
	5) of five residents re	5) of five residents reviewed for immunizations had either received their pneumococcal			The Unit Managers and/or Infection		
		ent # 5) or that staff followed			preventionist will clarify immunization		
		esident was eligible to			history for pneumonia vaccines for #4	and	
	receive one (Resider	receive one (Resident # 4). The findings included:			resident #5. The resident or resident representative will be education on the	•	
	1. Resident # 5 was a 7/4/22 and was over			risk and benefits, consent obtained, ar MD notified to obtain order per resider preference. Immunizations will be			
	Assessment, dated 7	rly Minimum Data Set /4/22, coded the resident as A review of Resident # 5's			provided per physician's order by 8/4/2022.		
		dent # 5's RP (Responsible			On 7/27/2022, the LPN Admissions		
	., .	nsent that Resident # 5 could			Coordinator initiated an audit of all		
	have the pneumonia	vaccine.			Pneumonia immunizations for all curre		
	A martine of Desident	# Flame and an 7/00/00			residents. This audit was to identify an		
		# 5's record on 7/22/22 5 had been immunized with			resident who had not received Pneumo vaccines as recommended by the CD0		
	the Pre-var 13 (one c				have a documented refusal of	5 01	
) on 11/14/20 but had never			immunization per facility protocol. The	RN	
	received the PPSV23				Infection Preventionist/Staff Developm		
	Pneumonia Vaccine	recommended for those over			Coordinator will address all concerns		
	the age of 65.). It wa				identified during the audit. Audit will be	;	
		3/22 at 1 PM that Resident #			completed by 8/9/2022.		
		PPSV23 and the staff should			On 8/5/2022 the Infection Draventionic	+	
		but the lack of immunization.			On 8/5/2022 the Infection Preventionis and unit managers and staff LPN initia		
		he unit managers were			an in-service with all nurses regarding		
		ing vaccines were given.			Immunizations with emphasis on educating resident on risks and benefi		
	2. Resident # 4 was	admitted to the facility on			vaccines, obtaining consent and physi		
	6/28/22.				order for vaccine per resident preferen	ice,	
					administering vaccine per physician or	der	

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	S FOR MEDICARE &				OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345478	B. WING		07/23/2022
AME OF PI	ROVIDER OR SUPPLIER	•	ST	IREET ADDRESS, CITY, STATE, ZIP CODE	-
IARNETT	WOODS NURSING AND	OREHABILITATION CENTER		04 LUCAS ROAD UNN, NC 28334	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIC
F 883	Continued From page	e 9	F 883		
	assessment, dated 7, cognitively impaired. On 7/22/22 a review revealed no history of administration. The Administrator wa 1:00 PM and again a reported that the staff following up on wheth pneumococcal vaccir facility by the residen and there still had no staff. According to the have been verified by	sion Minimum Data Set /4/22, coded Resident # 4 as of Resident # 4's record f pneumococcal vaccine as interviewed on 7/23/22 at t 3:45 PM. The Administrator f were supposed to be her Resident # 4 had had her nes prior to coming to the at's outside medical practice, t been any verification by her e Administrator, this should y the date of 7/23/22 in order hether they should offer the sident by way of her		with documentation in the electronic record and/or documentation of resider refusal if vaccine declined. The in-serv will be completed by 8/26/2022. All ne hired nurses will be in-serviced during orientation regarding Immunizations. Administrator will audit 10% of resider immunization record weekly x 4 weeks then monthly x 1 month utilizing the Immunization Audit Tool. This audit is ensure residents were educated on ris and benefits of Influenza and Pneumo vaccines, obtaining consent and physi order for vaccine per resident preferer administering vaccine per physician of with documentation in the electronic record and/or documentation of resider refusal if vaccine declined. The RN un managers and Infection Preventionist address all concerns identified during audit. The DON will review the Immunization Audit Tool weekly x 4 we then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward th results of the Immunization Audit Tool the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committe will meet monthly x 2 months and revi- the Immunization Audit Tool to determ trends and/or issues that may need further interventions put into place and determine the need for further and/or	vice wly at s to sks onia ician nce, rder ent it will the eeks e to eeks eeks eeks eeks
F 886 SS=D	COVID-19 Testing-Re	esidents & Staff	F 886	frequency of monitoring.	8/26/22

		ID HUMAN SERVICES MEDICAID SERVICES				08/18/2022 APPROVED 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		345478	B. WING		07/23	3/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
HARNETT	WOODS NURSING AND	REHABILITATION CENTER		604 LUCAS ROAD DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 886	Continued From page CFR(s): 483.80 (h)(1))-(6)	F 88	6		
	must test residents ar individuals providing s and volunteers, for Co for all residents and fa	services under arrangement				
	but not limited to: (i) Testing frequency; (ii) The identification of this paragraph diagno COVID-19 in the facil (iii) The identification this paragraph with sy consistent with COVII suspected exposure t (iv) The criteria for co asymptomatic individu paragraph, such as th	of any individual specified in osed with ity; of any individual specified in ymptoms D-19 or with known or to COVID-19; nducting testing of uals specified in this ne positivity rate of				
	help identify and prev transmission of COVI §483.80 (h)((2) Cond is consistent with curr conducting COVID-19 §483.80 (h)((3) For ea	e for test results; and cified by the Secretary that pent the D-19. uct testing in a manner that rent standards of practice for D tests; ach instance of testing: ting was completed and the				
		sot, and				

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		ND HUMAN SERVICES MEDICAID SERVICES					APPROVE 0. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345478	B. WING _			07/2	23/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
		D REHABILITATION CENTER		60	04 LUCAS ROAD		
HARNETT	WOODS NORSING AND	D REHABILITATION CENTER		D	UNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 886	Continued From pag	e 11	F	386			
1 000				000			
	(II) Document in the i was offered, complet	resident records that testing					
	· · ·	ing status), and the results of					
	each test.	ing status), and the results of					
	8483 80 (h)((4) Upor	n the identification of an					
	individual specified in						
	symptoms						
	consistent with COV	ID-19, or who tests positive					
	for COVID-19, take a	actions to prevent the					
	transmission of COV	'ID-19.					
	§483.80 (h)((5) Have	e procedures for addressing					
	residents and staff, in	ncluding individuals providing					
		gement and volunteers, who					
	refuse testing or are	unable to be tested.					
	§483.80 (h)((6) Whei	n necessary, such as in					
	emergencies due to	testing supply shortages,					
	contact state						
		artments to assist in testing					
		ining testing supplies or					
	processing test resul						
		T is not met as evidenced					
	by: Based on observation	on, record review, and staff			F886 COVID-19 Testing-Residents &		
		failed to assure testing was			Staff		
	-	er for Disease Control)					
		the accuracy of the results			On 7/22/22, dietary employee #1 (DE)		
		embers reviewed for COVID			was immediately re-tested for COVID		
		ailed to assure a staff			by the Director of Nursing (DON) and		
		esting for COVID, was			Infection Preventionist to ensure accur	racy	
		t the practice of testing. The			of testing. Dietary employee tested		
		wait at least 24 hours prior to			negative for SAR-CoV-2 infection. DE		
		er who had been exposed to			was in-serviced by the DON and Infect	tion	
		tive staff member per current			Preventionist to notify the nurse		
	CDC guidelines. The	e findings included:			immediately of any symptoms of		
					SAR-CoV-2 infection and testing would	d be	
	1. On 7/22/22 at 11:2	25 AM dietary employee (DE)			completed by the nurse.		

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		MEDICAID SERVICES				IO. 0938-03	
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345478			· ,	IULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING		0	07/23/2022		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE		
			604 LUCAS ROAD				
HARNETT WOODS NURSING AND REHABILITATION CENTER			DUNN, NC 28334				
(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	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 886	Continued From page	a 12	F 88	6			
1 000	# 1 was observed to		FOC				
		ere COVID testing materials		On 7/4/2022 nurse #3 was	retested and		
		gathered COVID testing		was negative for SAR-CoV			
		esting herself for COVID.					
		veyor if the surveyor knew		On 8/8/2022, the Administra	ator initiated		
		pposed to wait to get a result		COVID testing of all employ			
		"they" had told her to come		testing was completed accu			
		st was positive it would turn		and by designated trained s	• •		
		minutes. DE # 1 stated her		test results were document			
	-	she just wanted to make		testing log per facility guide	lines. The		
	-	e COVID. DE # 1 did not		Director of Nursing, RN uni			
	know if there was sup	pposed to be someone who		Infection Preventionist and	-		
	was to be helping her	with the test. Immediately		address all concerns identit	fied during the		
	following the observa	tion, Nurse Consultant # 1		audit to include re-testing s	taff when		
	was located in a diffe	rent part of the facility by the		indicated and/or retraining	of staff. Testing		
		sultant # 1 was informed that		will be completed by 8/26/2	.022.		
	-	erself for COVID and was					
		was to wait for the results.		On 7/26/2022 the Infection			
		responded that someone		Director of Nursing, Staff Ll			
	would help DE # 1.			managers initiated an in-se			
				nurses, nursing assistants,			
		M the facility's Infection		staff, accounts payable, acc			
		s interviewed and reported		receivable, social worker, n			
	the following. DE # 1 had been retested by her			staff, dietary staff, therapy s			
		ursing (DON) that day to		receptionist/screeners, med			
	make sure it was done correctly and DE # 1 tested negative. She and the DON had talked to			and activities staff regarding			
	•	and the DON had taked to eyor had observed DE # 1		Testing with emphasis on C for testing to include not co			
		arned that no one in a		testing less than 24 hours f			
				of SAR-CoV-2 infection and			
	supervisory position had told DE # 1 to test herself. DE # 1 had been talking to the other			completed only by designat	-		
		s earlier that day and let		to ensure accuracy of testir			
	-	ot "feel all that great." The		documentation of test resul	•		
		-		will be completed by 8/26/2			
	other staff members had told her she could go test herself and that "it only takes a minute or			8/26/2022, any nurses, nurs			
		d it was the facility's system		admission staff, accounts p	-		
		ho had COVID symptoms		accounts receivable, social			
		a nurse. The nurses were		maintenance staff, dietary s			
		testing procedures and		staff, receptionist/screeners			

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		MEDICAID SERVICES			OMB NO. 0938-0	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345478		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED 07/23/2022			
		B. WING				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HARNETT WOODS NURSING AND REHABILITATION CENTER						
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET	
F 886			F 88			
	IP stated there was a the dietary departme	re it was done correctly. The nursing station right outside nt and DE # 1 should have to a nurse she was not		records, and activities staff who has received the in-service will comple- training prior to next scheduled wo All newly hired nurses, nursing as admission staff, accounts payable	complete uled work shift. sing assistants,	
	The Medical Director at 1:45 PM and report only be a few people	was interviewed on 7/23/22 ted he felt that there should , who were trained in correct ated as the staff members to		accounts receivable, social worker maintenance staff, dietary staff, th staff, receptionist/screeners, media records, and activities staff will be in-serviced during orientation rega COVID Testing.	, erapy cal	
	2. Review of the Cen guidelines for testing revealed the following (health care personn higher-risk exposure close contacts, regar should be tested as of section. For those wh SARS-CoV-2 infection perform SARS-CoV-2 generally not earlier the exposure) and, if neg the exposure."" Review of facility trac positive employees to COVID positive on 6/ contract tracing recon work with Nurse # 20 results revealed the f	ter for Disease Control , updated on 1/21/22, g information. "All HCP el) who have had a and residents who have had dless of vaccination status, described in the testing no have not recovered from in in the prior 90 days, 2 testing immediately (but than 24 hours after the pative, again 5-7 days after excling information for COVID evealed Nurse # 2 tested (27/22. According to the rds, Nurse # 3 had ridden to on 6/27/22. Review of testing facility tested Nurse # 3 on was exposed while riding to		The Unit Managers and/or Infectio Preventionist will monitor COVID t of employees weekly x 4 weeks th monthly x 1 month utilizing COVID Audit Tool, This audit is to ensure facility follows CDC guidelines on testing to include not completing te less than 24 hours from exposure SAR-CoV-2 infection and testing to completed only by designated train to ensure accuracy of testing with documentation of test results. The Managers and/or Infection Preven will address all concerns identified the audit to include but not limited re-testing of staff when indicated b designated trained staff for accura testing with documentation of test and/or re-training of staff. The Dire Nursing will review the COVID Tes Audit Tool weekly x 4 weeks then x 1 month to ensure all concerns w	esting en Testing the COVID esting of b be hed staff Unit tionist during to y cy of results ector of ting monthly	
	facility did not wait to after her initial expos on 6/27/22). Interview	3/22 at 3:45 PM revealed the test Nurse # 3 for 24 hours ure (which was her car ride v with the Administrator and rds revealed Nurse # 3		addressed. The Director of Nursing will forwar results of the COVID Testing Audit the Executive Quality Assurance		

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE		
		A. BUILDING	COMP	COMPLETED		
		345478	B. WING		07/	23/2022
NAME OF P	ROVIDER OR SUPPLIER	·	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
HARNETT WOODS NURSING AND REHABILITATION CENTER			6			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 886	1 0	e 14 VID from the exposure.	F 886	Committee monthly x 2 months. The		
				Executive Quality Assurance Comm will meet monthly x 2 months and re the COVID Testing Audit Tool to det trends and/or issues that may need further interventions put into place a determine the need for further and/o frequency of monitoring.	eview ermine and	
			F 887			8/26/22
	F 887 SS=DCOVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii)§483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/18/2 FORM APPRO OMB NO. 0938-0	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345478	B. WING		07/23/2022	
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO		
HARNETT	WOODS NURSING AND	REHABILITATION CENTER		604 LUCAS ROAD DUNN, NC 28334		
(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 TI DEFICIENC'	ON SHOULD BE COMPLET HE APPROPRIATE DATE	
F 887	the opportunity to acc vaccine, and change Note: States that are Final Rule - 6 [CMS-3 requirements of 483.3 under IFC-5 [CMS-32 and (vi) The resident's me documentation that in the following: (A) That the resident was provided educati benefits and potentia COVID-19 vaccine; a (B) Each dose of CO to the resident; or (C) If the resident did vaccine due to medic contraindications or r (vii) The facility main to staff COVID-19 va includes at a minimum (A) That staff were pr the benefits and potentian (C) The COVID-19 va information on obtain (C) The COVID-19 va related information as Disease Control and Healthcare Safety Ne This REQUIREMENT by: Based on record rev facility failed to assur	esident representative, has cept or refuse a COVID-19 their decision; not subject to the Interim 3415-IFC], must comply with 80(d)(3)(v) that apply to staff 414-IFC] edical record includes ndicates, at a minimum, or resident representative ion regarding the I risks associated with and VID-19 vaccine administered not receive the COVID-19 eal efusal; and tains documentation related ccination that m, the following: ovided education regarding ntial risks ID-19 vaccine; I the COVID-19 vaccine or ing COVID-19 vaccine; and accine status of staff and is indicated by the Centers for Prevention's National etwork (NHSN). T is not met as evidenced iew and staff interview the e one (Resident # 4) of two	F 8	F887 COVID-19 Immuniza		
	COVID received their	no were not vaccinated for r COVID vaccine per their noice to follow guidelines		On 8/2/2022 resident #4 wa risks/benefits and potential COVID vaccine/boosters by	side effects of	

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		MEDICAID SERVICES	(X2) MULTIPLI	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED		
		345478	B. WING		07/23/2022
IAME OF PI	ROVIDER OR SUPPLIER		ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE	
HARNETT WOODS NURSING AND REHABILITATION CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLET
F 887	Continued From page	e 16	F 887	,	
				manager and was administered vaccine per resident preference documentation in the electronic	with
	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION) 887 Continued From page 16 and have the vaccine administered. The findings			On 7/28/2022 the administrator i an audit of all current residents of vaccine status. This audit was to any resident who had not been p Covid 19 vaccine/booster per respreference or a documented refu- immunization per facility protoco Director of Nursing, RN unit mar Infection preventionist, and Staff address all concerns identified d audit to include educating resider risks/benefits and potential side associated with the vaccine, obta consent and administering vaccine/booster per resident pre- or documenting resident refusal electronic record. Audit will be co by 8/9/2022. On 8/5/2022, the Infection Preve- and Staff LPN initiated an in-ser all nurses regarding Immunization Emphasis on educating resident pre- or administering vaccine per physion with documentation in the electror record and/or documentation of refusal if vaccine declined. In-ser be completed by 8/26/2022. All if hired nurses will be in-serviced of orientation in regards regarding	nitiated Covid 19 o identify provided a sident usal of I. The hagers, f LPN will uring the ent on effects aining ference in the pompleted entionist vice with ons. on risks, is of physician eference, cian order onic resident rvice will hewly

Event ID: 2QW311

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345478		(X2) MULTIPL A. BUILDING	OMB NO. 0938- (X3) DATE SURVEY COMPLETED			
		B. WING	07/23/2022			
NAME OF PROVIDER OR SUPPLIER HARNETT WOODS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 604 LUCAS ROAD DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE COMPLI TO THE APPROPRIATE DAT	
F 887	Continued From page	ge 17	F 88	Administrator will audit 1 immunization record wey then monthly x 1 month Immunization Audit Tool ensure residents were e benefits and potential sid Covid 19 vaccines, obta physician order for vacci preference, administerin physician order with door electronic record and/or resident refusal if vaccin RN unit managers, Infect Staff LPN will address a identified during the aud educating the resident, or notification of physician indicated and providing resident preference with vaccine provided in the or documentation of refu- declined. The DON will f Immunization Audit Tool then monthly x 1 month concerns were addressed The Director of Nursing results of the Immunizati the Executive Quality Assura- will meet monthly x 2 month trends and/or issues tha further interventions put determine the need for f frequency of monitoring	ekly x 4 weeks utilizing the . This audit is to ducated on risks, de effects of ining consent and ine per resident g vaccine per sumentation in the documentation of us declined. The stion Preventionist, Il concerns it to include obtaining consent, for order when vaccine per documentation electronic record usal if resident review the weekly x 4 weeks to ensure all ed. will forward the ion Audit Tool to ssurance months. The ance Committee onths and review Tool to determine t may need into place and	

Facility ID: 924467

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