

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HAYWOOD NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 690 SS=D	<p>Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)</p> <p>§483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff</p>	F 690	"Preparation and/or execution of this plan	3/28/19
---------------	---	-------	--	---------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/29/2019
--	-------	-----------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2019
NAME OF PROVIDER OR SUPPLIER HAYWOOD NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 690	<p>Continued From page 1</p> <p>interviews, the facility failed to prevent tubing of a urinary catheter from touching the floor for 1 of 1 residents reviewed for urinary catheters (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility 12/08/18 with diagnoses which included infection and inflammatory reaction due to indwelling urethral catheter, Alzheimer's disease, and neuromuscular dysfunction of the bladder (dysfunction of nerves that cause inability to pass urine without use of a catheter).</p> <p>A physician order dated 12/10/18 noted Resident #1 was to receive catheter care every shift.</p> <p>A baseline care plan dated 12/12/18 identified Resident #1 had an indwelling suprapubic catheter related to a neuromuscular bladder. Goals included the resident would not demonstrate signs or symptoms of a UTI through the next review date. Interventions included position catheter bag and tubing below the level of the bladder. The care plan was updated 03/07/19 which revealed antibiotic therapy was received related to an UTI. The goal was to be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Interventions included administer antibiotic medications as ordered by physician. Observe and document side effects and effectiveness of medication every shift.</p> <p>Review of the admission Minimum Data Set (MDS) dated 12/15/18 assessed Resident #1's cognitive status was severely impaired and needed extensive assistance with bed mobility,</p>	F 690	<p>of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it the required by the provisions of federal and state law."</p> <p>F690</p> <p>1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:</p> <p>A.) Per the 2567, on 3/11/19 Resident #1 was observed sitting in his wheelchair with his catheter tubing touching the floor. Upon identification of the tubing touching the floor, the staff secured the catheter tubing inside the privacy bag to ensure the catheter tubing was not touching the floor.</p> <p>2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited:</p> <p>A.) On 3/12/19 current nursing and agency staff were educated by the Assistant Director of Nursing on catheter care including tubing securement, prior to continuing work. Agency staff and New Hires will be trained on catheter care during orientation by the Director of Nursing or Designee.</p> <p>B.) On 3/26/19 an audit of all residents receiving catheter care was conducted to ensure catheter tubing was secured.</p> <p>3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2019
NAME OF PROVIDER OR SUPPLIER HAYWOOD NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 690	<p>Continued From page 2</p> <p>transfers, personal hygiene, and toilet use. An indwelling catheter was in place for urinary and was always incontinent of bowel. The care area assessment (CAA) section of the MDS described Resident #1 was admitted to the facility after hospitalization for a catheter associated urinary tract infection (UTI) with diagnosis of neuromuscular bladder and dementia. Resident #1 required extensive assistance with toileting, had a suprapubic catheter, and was at risk for a UTI.</p> <p>Review of the Treatment Administration Record revealed nurses initialed catheter care was provided every shift at 7:00 AM, 3:00 PM, and 11:00 PM from 03/01/19 through 03/11/19.</p> <p>An observation on 03/11/19 at 3:30 PM revealed Resident #1 was sitting in a wheelchair at the foot of the bed. The catheter bag remained attached to the side of the bed with the tubing touching the floor. Resident #1 was observed to roll over the tubing with the wheelchair two times during the observation. Resident #1 placed the tubing over the foot rest of the wheelchair to prevent rolling over. A second observation on 03/11/19 at 4:07 PM revealed the catheter bag was attached underneath the seat of the wheelchair with the tubing touching the floor while Resident #1 self-propelled down the hallway of the facility.</p> <p>During an observation on 03/11/19 at 4:42 PM Nurse Aide #1 provided catheter care and when finished she attached the bag underneath the wheelchair with the tubing touching the floor.</p> <p>An interview conducted on 03/11/19 at 5:01 PM Nurse Aide #1 stated she was finished with catheter care and confirmed the tubing was</p>	F 690	<p>A.) The Director of Nursing or designee will randomly observe each resident with a catheter to ensure that the catheter tubing is secured appropriately daily for 4 weeks, then once weekly for 3 months. The Director of Nursing will review these audits and report the findings at the monthly QAPI meeting x 3 months.</p> <p>4.) The title of the person responsible for implementing the acceptable plan of correction; The Director of Nursing is responsible for implementing the corrective actions.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2019
NAME OF PROVIDER OR SUPPLIER HAYWOOD NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 690	<p>Continued From page 3</p> <p>touching the floor. She was aware tubing shouldn't touch the floor because bacteria could contaminate the catheter. She explained the catheter bag was attached underneath the wheelchair to keep it below the bladder and prevent the back flow of urine. Nurse Aide #1 stated she was unsure how to prevent the tubing from touching the floor when attached underneath the wheelchair but would ask the nurse.</p> <p>During an interview on 03/12/19 at 8:48 AM the Director of Nursing revealed it was her expectation Nurse Aides would keep catheter tubing off the floor and this was considered part of catheter care. She explained a guide generated by residents' care plan was used and if an intervention was in place it was available for Nurse Aides to use as a reference. She stated nurses check the placement of catheter tubing and sign the residents' Treatment Administration Record every shift.</p>	F 690			