STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING _____ B. WING _____	C 03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

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F 000	INITIAL COMMENTS No citations cited as a result of complaint investigation survey event id: ZQ6G11.	F 000	The Laurels of Hendersonville wishes to have this submitted plan of correction stand as its allegation of compliance. Our alleged compliance date is April 5, 2012.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record review, the facility failed to trim facial hair on one (1) of three (3) dependent female residents (Resident #119). The findings are: Resident # 119 was admitted to the facility with a diagnosis of multiple fractures from a fall. The most recent Minimum Data Set (MDS), dated 01/09/12, revealed the resident had short and long term memory loss and was severely impaired in cognitive skills for daily decision making. The MDS also revealed the resident required extensive assistance with most activities of daily living (ADL), including grooming. The resident's care plan, dated 01/19/12, addressed the need for assistance with ADL, including the removal of facial hair as needed. On 03/13/12 at 1:37 PM Resident #119 was observed in the front lobby of the facility in her	F 312	Preparation and/or execution of this plan 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 is required by the provisions of Federal and State law. Resident #119's facial hair has been removed and her nursing assistant care card has been updated to include removal of facial hair as needed. Current residents were observed for facial hair and hair removed when indicated. The Staff Development Coordinator/designee will in-service all nurses and C.N.A.s regarding resident grooming with attention to facial hair for both men and women. RECEIVED APR 13 2012 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

NHA | 4/13/2012

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.

Original Signature Date : 4-4-12

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F 312	Continued From page 1 wheelchair. The resident had multiple facial hairs under her chin approximately 3/8 of an inch long. Resident # 119 was also observed on 03/14/12 at 12:20 PM and on 03/15/12 at 12:10 PM in her wheelchair in the main dining room. At these times, she was again observed to have multiple facial hairs under her chin approximately 3/8 inch long. On 03/15/12 at 3:22 PM Nursing Assistant #1 was interviewed. She stated she usually worked on the hall where Resident #119 resided. She stated that facial hair on women was assessed and trimmed during the twice weekly shower days for each resident. She also stated that anytime a resident needed it facial hair should be trimmed or shaved. On 03/15/12 at 3:28 PM Licensed Nurse #1 was interviewed. She stated that facial hair on female residents should be trimmed during twice weekly showers and any time the nursing assistant noticed it needed trimming. She stated she expected nursing assistants to check for facial hair on female residents and trim it as needed as part of morning care each day. On 03/15/12 at 3:50 PM the Director of Nursing (DON) was interviewed. She stated facial hair on dependent female residents should be trimmed on shower days and anytime it is needed. She stated she expected nursing assistants to evaluate the need to trim facial care as part of morning care for each resident. The DON observed the facial hairs on Resident #119 at this time and stated staff should have noticed and trimmed them.	F 312	Facial hair will be observed (3) three times a week for the next (4) four weeks by department managers, and residents in need of shaving will be reported to the charge nurse and assigned nursing assistant if action is needed. Observation results will be reported to the Director of Nurses weekly for the next (4) four weeks and concerns will be reported to the quality assurance committee during the monthly meeting. Continued compliance will be monitored through routine daily round observations and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident, and family interviews, and medical record review, the facility failed to provide sufficient space for safe ambulation by residents within one (1) of two (2) dining rooms (Residents # 12, 14, 24, 43, 48, 55, 72, 89, 94, 96, 120, 126, 162, 171, 173). The findings are: On 03/13/12 from 12:20 PM until 12:54 PM an observation was made of seventeen residents dining at lunch in the Heritage Dining Room, a dining room reserved for residents considered by the facility to be alert and oriented and able to feed themselves. There were seventeen residents present, thirteen of them in wheelchairs and four with walkers. There were three visiting family members and one nursing assistant to assist residents as needed. There were six dining tables in the room, two on one side of the room, three on the other side, and one table against the wall in the back of the room. There was a narrow center aisle between the rows of tables At 12:20 PM Resident #94 was asked by staff to	F 464	The facility removed and rearranged furniture and seating during the survey to ensure that sufficient space was provided for safe ambulation by residents in the Heritage dining room. The changes were accepted and supported by the residents utilizing this dining room. The meal service in the Heritage Dining room will be monitored (3) three times a week by a member of the IDT team for the next (2) weeks to ensure the flow of traffic in and out of the dining room facilitates residents' needs. Changes will be made when indicated, concerns will be reported to the Administrator and to the quality assurance committee during the monthly meeting. All Staff assisting in the dining room was in-serviced by the Staff Development Coordinator/designee on monitoring for safe ambulation and maneuvering of residents while in the Heritage Dining Room as not to interrupt residents while they are eating and to report concerns to the administrator or his/her designee.	

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F 464	Continued From page 3 move away from her place at her table so a resident entering the room could get by. When Resident #94 was back in place she immediately was asked to move again to allow another resident to pass. Also at 12:21 PM Resident #12 who was seated at a back table had finished her meal and attempted to leave in her wheelchair. Resident #55 had to move her wheelchair completely away from the place she was eating, and Residents #171, and #162 had to scoot their chairs closer to the table to allow Resident #12 to enter the center aisle and exit. At 12:25 PM Resident #14 stated, "We need a bigger room." At 12:30 PM Resident #96 entered the room using a walker and attempted to ambulate through the center aisle to her assigned seat. Resident #89 was sitting in a chair at her table with her walker alongside with her back to the center aisle. Resident #120 was in her wheelchair across the center aisle at another table also with her back to the aisle. Resident #96 tried to move between these two residents but the gap was too small to get her walker through. A staff member moved Resident #89 closer to the table to allow Resident #96 to pass. The Director of Nursing was present and observed the residents having to move. She stated, "I think we need a bigger room." She stated the room was for alert and oriented residents who were independent in dining. The DON noted there were many long term residents who dined in this dining room but that recently more short term rehab residents had also been using the room which filled it up.	F 464	The Facility will continue to ensure that sufficient space is provided for residents using this dining room as the population changes through random observations of meal service, queries of identified residents, and through the facility's quality assurance program. Concerns will be reported to the administrator or his/her designee daily and adjustments will be made as needed.	

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F 464	Continued From page 4 At 12:50 PM Resident #173 tried to leave in her wheelchair but could not get through the narrow center aisle. Staff moved one table to allow her through but also asked Resident #89 to move her chair and walker to allow Resident #173 to pass. At 12:54 PM Resident #43 attempted to leave through the center aisle in her wheelchair but could not get through the aisle. Resident #89 had to move her walker for the resident to pass through. At 1:00 PM Resident #89 was interviewed. She stated she always ate lunch and dinner in the Heritage Dining Room. She stated it was very crowded in there every day and that she did not like it when she would start to take a bite then have to move her chair or walker. But she stated she understood that residents had to get in and out. She noted that the residents had re-arranged the tables with help from a family member into an easier configuration but someone had moved the tables back. Resident #89 stated she was worried about residents being able to get out in an emergency. On 03/14/12 from 12:09 PM until 1:13 PM a second observation was made of fourteen residents dining at lunch in the Heritage Dining Room. There were two visiting family members. The room was arranged like the previous day. At 12:09 PM Resident #48 was sitting in her wheelchair at the table nearest the door. Nursing Assistant (NA) #2 moved her away from her table to allow another resident to enter the center aisle in her wheelchair. At the same time Resident	F 464		

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F 464	Continued From page 5 #126 entered the dining room with her walker and moved towards her table. Resident #126 had to move chairs out of her way in order to access her seat. At 12:22 PM Resident #96 was observed to be eating her salad. She had to interrupt her meal and back her wheelchair into the center aisle to allow Resident #24 to maneuver her wheelchair to her table. At 12:30 PM Resident #72 was eating in her wheelchair at the table closest to the door. Directly across the center aisle, Resident #120 was eating in her wheelchair at another table with her family member. The gap between the two residents was approximately twenty to twenty-four inches. Resident #171 entered with his walker and attempted to move through the gap and down the center aisle. He was unable to get through with his walker in the usual position so he turned it sideways and pushed it through ahead of him then turned sideways himself and stepped through. At 12:43 PM Resident #43 attempted to leave in her wheelchair but could not move between the other two wheelchairs. The family member of Resident #120 moved her in her wheelchair away from the table to allow the resident to pass. The family member commented that there was not enough room. The family member had to move Resident #120 again at 12:48 PM to allow Resident # 173 to pass. At 12:50 PM Resident #12 turned her walker to the side to squeeze through the wheelchairs, and at 12:55 PM Resident #171 tried to move	F 464		

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F 464	Continued From page 6 between the wheelchairs to exit. Resident #171 again pushed his walker through the opening sideways. The walker got hung up on one of the wheelchairs and NA #2 had to assist the resident to untangle it. At 12:51 PM the family member of Resident #120 again had to move the resident to allow Resident #94 to pass. At 1:11 PM staff had to move a table to allow Resident #14 to exit in her wheelchair and Resident #89 with her walker. At 1:13 PM most residents were finished eating and had exited. The family member of Resident #120 was observed assisting a staff member to rearrange the tables to provide easier entrance and exit for the next meal. On 03/14/12 at 1:19 PM NA #2 was interviewed. She stated Heritage Dining Room has been overcrowded with residents for approximately two months, with residents having to move in order to allow other residents to enter or exit. She stated about two months ago another table was added at the back wall to accommodate more residents. She stated she had noticed that Resident #171 had gotten his walker hung up on a wheelchair and noted that was a hazard. She stated that she and the family member of Resident #120 had tried rearranging the tables several times for better access but they were always moved back to the original position by other staff before the next meal. NA #2 stated she had reported the problem of congestion in the dining room to kitchen staff but had not mentioned it to administrative staff.	F 464		

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F 464	Continued From page 7 On 03/14/12 at 1:40 PM the family member of Resident #120 was interviewed. He stated the dining room is crowded and he often had to move his family member to allow residents to enter or exit. But he stated that the tables could be arranged in a way that provided easier access for residents. He stated that he and NA #2 had tried rearranging the tables but someone always moved them back. The family member stated there was no communication among departments about addressing the problem. On 03/15/12 at 10:10 AM the Resident Council President who dined in the Heritage Dining Room, Resident #72, was interviewed. She stated the overcrowding in the dining room had been going on for at least a month. She stated it had not come up at the Resident Council Meeting because it was a recent problem. On 03/15/12 at 12:27 PM the Administrator was interviewed. He stated he was informed of the crowded room about a month ago and added a back table for more residents. He stated if there had been continued problems he would expect that staff would inform him. The Administrator stated that his expectation was that residents should have a clear path to enter and exit.	F 464		