STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE HEALTH AND REHABILITATION	104 COLLEGE DRIVE FLAT ROCK, NC 28731

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and medical record review the facility failed to honor food preferences for one 1 of 1 sampled resident. (Resident # 100). The findings are: Resident #100 was admitted to the facility on 04/19/11 with diagnoses including diabetes mellitus, hypertension, and gall bladder stones. The latest Minimum Data Set dated 09/10/12 revealed Resident #100 was assessed as cognitively intact with no confusion. At the time of Resident #100's admission a "Diet History/Food Preference List" dated 04/20/11 indicated no dislikes stated at the time. The only preferences listed were beverage preferences such as tea and grape juice. Further record review revealed a physician order dated 08/01/11 for Resident #100 to have a nutritional supplement and jello on each meal tray. An interview with Resident #100 was conducted	F 242	*Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.* *Hendersonville Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is December 7, 2012.* 1. Resident #100 was interviewed regarding her food preferences. A Diet History/Food Preference List was completed. The dietary manager was provided a typed list of food preferences, including likes and dislikes Resident #100's tray card was reviewed and revised to verify her disliked food items were indicated on the tray card. Tray line staff verifies her tray is served based upon her wishes as indicated on her tray card prior to leaving the kitchen. Resident #100 will be monitored by the Dietary Manager or her designee on a weekly basis for 4 weeks, then monthly and randomly thereafter to determine she is receiving food based upon her preferences, likes and dislikes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12

DHSR Black Mountain WRO Received DEC 06 2012 by:

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F 242	Continued From page 1 on 11/06/12 at 5:03 PM. She stated she required soft foods to eat because of her gall bladder condition. Resident #100 stated a typed list of food preferences was provided to the dietary manager in August 2012. An observation at this time of this list dated 08/14/12 revealed jello was included as a food preference. Observation of Resident #100's supper tray on 11/06/12 at 5:50 PM revealed Resident #100 was served a chocolate nutritional supplement and no jello. Review of the resident's tray card on the supper tray revealed chocolate was listed as a disliked food item. The resident stated she does not like chocolate and would not eat the chocolate nutritional supplement. She added she had received it a couple of times in the last ten days. In addition, the resident said she had requested jello and has not seen it on her meal tray in over a week. Observation of Resident #100's lunch tray on 11/08/12 at 1:05 PM revealed she had no jello. At this time the resident repeated she had not had jello on her tray for over a week. An interview with the Certified Dietary Manager (CDM) was conducted on 11/08/12 at 1:41 PM. The CDM revealed there was three dietary staff on the tray line. The first dietary staff member informed the cooks of the dislikes on the slip. The second dietary staff member checked to make sure nothing was missing on the tray. The third dietary staff member rechecked the tray to make sure food items were not placed on the tray that were listed as disliked. The CDM stated she expected that all three dietary staff members on the tray line would make sure to review the tray	F 242	Resident #100's food preferences, likes and dislikes will be reviewed and revised during each quarterly care planning session. 2. All resident's tray cards have been evaluated by the Certified Dietary Manager to ensure likes and dislikes with food preferences are indicated on each individual tray card. Dietary staff members on the tray line have been re-educated and will review each tray card while preparing each meal tray to assure each resident's food preferences are honored. • First dietary staff member informs the cooks of dislikes on card • Second dietary staff member checks to make sure nothing was missing on the tray • Third dietary staff member rechecks tray to make sure food items were not placed on tray that were listed as disliked 3. An audit of each resident's food preferences, likes and dislikes will be conducted at least quarterly to determine each resident is receiving food based upon his/her preferences, likes and dislikes. Each resident's food preferences, likes and dislikes will be reviewed and revised	

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F 242	Continued From page 2 slip while preparing each meal tray to assure residents food preferences were honored. The CDM said Resident #100 should have received jello on her meal trays and not received chocolate as per the resident's listed dislikes.	F 242	during each quarterly care planning session. Observation and monitoring of the tray line will be conducted by the certified dietary manager or her designee on a weekly basis x 4 weeks, then monthly and randomly thereafter.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow a care plan by not completing skin assessments consistently for 1 of 4 residents reviewed for skin assessment availability (Resident #113). The facility also failed to follow a care plan regarding treatment of constipation for 1 of 11 residents reviewed for bowel movement monitoring (Resident #32). The findings are: 1. Review of a facility policy/procedure titled "Skin Assessment" dated August, 2011 revealed the unit nurse would assess the resident's skin on day of admission. A complete comprehensive head to toe assessment of the resident's skin would be completed once a week thereafter. Documentation of the status of the resident's skin would be provided in the resident's chart once per week. Resident #113 was admitted to the facility with	F 282	4. The Certified Dietary Manager or designee will audit documentation in each resident's medical record to ensure physician orders and resident preferences are followed and documented and will report to the Quality Assurance Committee on a monthly basis x 3 months, then quarterly thereafter to ensure resident's dietary preferences, likes and dislikes are being honored. 1. A. Resident #113 has been reassessed and care plan has been updated to include specific interventions to address skin integrity. A head-to-toe assessment has been completed on resident #113 and documented in the medical record on the Nursing Assessment form. A skin assessment was performed by a licensed nurse and documented in the medical record on the Skin Assessment Form.	12-7-12

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F 282	Continued From page 3 diagnoses including malnutrition and aftercare joint replacement. An admission Minimum Data Set (MDS) dated 09/15/12 revealed Resident #113 was understood, understands and was able to make her needs known. The MDS also revealed Resident #113 was at risk for developing pressure ulcers which triggered for a care area assessment and care plan development. Review of a nursing care plan dated 09/08/12 indicated Resident #113 had a potential risk for skin breakdown related to immobility and weakness from recent hospitalizations. The documented goal was for the resident to remain free from tissue injury through preventative nursing measures through the next review of 12/06/12. Interventions in place included: assess skin weekly per facility protocol, notify nurse and physician of any new areas noted, and exercise caution during transfers and handling as skin is fragile. An admission nursing assessment was completed on 09/08/12 which included a skin condition assessment. The skin assessment described an area on Resident #113's left hip as warm, reddened, dry skin with edema. In the comments section, documentation revealed; "see nurse's notes for details." Review of a nurse's note dated 09/08/12 revealed Resident #113 had "multiple skin issues" and "skin is dry and flaky everywhere." The nurse's note further revealed a "quarter size blood blister" behind the resident's right knee, buttocks appeared excoriated and the presence of a rash on the resident's back and neck.	F 282	Assessment of resident #113 will be performed by a licensed nurse will be completed weekly and documented in the medical record on the Weekly Skin Assessment form B. During the survey, documentation to indicate extended times without bowel movement had been addressed for Resident #32. Resident #32 has been reassessed and care plan has been updated to include specific interventions to address incontinence, bowel movement monitoring and treatment of constipation. MDS Comprehensive Assessment was reviewed to ensure resident status is consistent with nursing assessments and documentation. Care Area Assessment has been reviewed and revised to include problem area for resident at risk for constipation related to medications and history. Certified nursing assistants have been re-educated and utilize the electronic system to document bowel movements every shift for each resident, including Resident #32. Daily reports containing resident-specific information detailing bowel movement frequency are generated from electronic system by each unit manager. The daily	

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F 282	Continued From page 4 Review of a nurse's note dated 11/02/12 at 6:00 PM revealed Resident #113 had a new area of skin breakdown on upper left buttocks approximately 2 centimeters (cm) by 3 cm with undeterminable depth. Review of a "Weekly Skin Assessment" dated 11/07/12 revealed Resident #113 had an open area located on the right inner buttock, an open area located on the left lower leg and a scratch on the left upper hip. Further review of Resident #113's medical record did not reveal any other weekly skin assessments. On 11/08/12 at 10:00 AM the Director of Nursing (DON) was interviewed and indicated the nurse was responsible for completing weekly head to toe skin assessments according to care planning and facility policy. The DON also indicated Resident #113 should have had skin assessments documented in the medical record. An interview with Nurse #3, a unit manager, on 11/08/12 at 2:30 PM revealed nurses were supposed to do weekly skin assessments and document findings on the "Weekly Skin Assessment" form. Nurse #3 also revealed if a resident had an area of concern the nurse would report the findings to her. 2. Resident #32 was admitted to the facility 07/26/12 with diagnoses which included Alzheimer's dementia, osteoporosis, depression and constipation. The 10/19/12 quarterly Minimum Data Set (MDS)	F 282	reports indicate when resident has bowel movements and indicates warnings when resident has gone three days without a bowel movement. Each Unit Manager provides the daily bowel movement tracking report to the charge nurse on each hall. The daily report is being provided to the nurse on the hall where resident #32 resides. Upon receipt of the daily bowel movement tracking report, the charge nurse will address any issues when the resident had gone three days without a bowel movement, sign the report and return it to the Unit Manager for verification. 2. A. A head-to-toe assessment has been completed on every resident in-house and documented in the medical record on the Nursing Assessment form. A skin assessment was performed on each resident in-house by a licensed nurse and documented in the medical record on the Skin Assessment Form. A Skin Integrity Program has been developed which is coordinated by a Skin Integrity Nurse. The Skin Integrity Nurse will provide monitoring of each Skin Assessment and will coordinate services to be provided to prevent skin breakdown and promote healing of areas of loss of skin integrity.	

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F 282	Continued From page 5 assessment for Resident #32 assessed her with severe cognitive impairment and requiring extensive assistance for toileting. The 08/02/12 admission MDS for Resident #32 triggered the area of incontinence. The Care Area Assessment related to this assessment noted, "Resident incontinent requiring staff assist with activities of daily living, no current skin concerns but at risk for skin breakdown, working with therapy. No current bowel movement noted in computer but with nurse interview resident had bowel movement and not constipated, at risk for with Lasix daily". "Will proceed to care plan for incontinent care, risk for skin breakdown, constipation and needs for activities of daily living and toileting". The 08/15/12 initial care plan included the problem area "Resident is at risk for constipation related to medications and history". This problem area continued when the care plan was reviewed again on 10/09/12. Approaches to address the problem area included: *Assess/record/report to MD as needed signs/symptoms of constipation such as abdominal pain, abdominal distention, straining of stool, hard stool, nausea, vomiting and altered mental status *Administer laxatives, stool softeners as ordered and monitor for side effects and effectiveness *Obtain and monitor lab/diagnostic work as ordered and report abnormal values to physician *Monitor bowel movement pattern and record on flow sheet *Encourage adequate fluid intake unless contraindicated *Encourage foods high in fiber unless	F 282	An Assessment will be performed for each resident upon admission and weekly thereafter. The Skin Assessment form will be placed in the Skin Integrity Nurse's file. She will evaluate each assessment and determine which residents need further intervention or referral to our wound care physician for a specific treatment regimen. The Skin Integrity Nurse will place the Skin Assessment form in each resident's medical record. Each resident identified upon admission or during weekly skin assessments who has a loss of skin integrity will have their care plan reviewed and revised as needed. The interventions will be placed on the Working Plan of Care in addition to the Interdisciplinary Comprehensive Care Plan. 8. Each resident with incontinence or propensity to constipation has been reassessed and their Working Plan of Care has been updated to include specific interventions to address incontinence, bowel movement monitoring and treatment of constipation. The Interdisciplinary Care Plan will be reviewed and revised quarterly to ensure resident needs related to incontinence, need for bowel movement monitoring and treatment for constipation are addressed. MDS Comprehensive Assessments will be reviewed quarterly to ensure resident status is consistent with nursing assessments and documentation.	

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F 282	Continued From page 6 contraindicated. Review of physician orders revealed that since admission 07/26/12, medications for Resident #32 included: *Fibercon 625 milligrams (mg), 2 tablets every day for constipation *Senokot 2 tablets by mouth at bedtime for constipation *Dulcolax 10 mg suppository every three days as needed if no bowel movement In addition, physician orders revealed the diet order since admission for Resident #32 included nectar thick liquids. Review of October bowel records for Resident #32 revealed the following time frames without a documented bowel movement: 10/17/12 first shift-10/23/12 second shift (a six day period) 10/25/12 third shift-10/30/12 second shift (a five day period) Review of the October Medication Administration Record revealed Resident #32 did not receive a Dulcolax suppository between 10/17/12-10/23/12 and 10/25/12-10/30/12. On 11/8/12 at 10:10 AM the Unit Coordinator (over the unit Resident #32 resided) stated the facility had an electronic system which nursing assistants utilized to document bowel movements every shift for each resident. The Unit Coordinator stated a daily report was generated from this electronic system by either the unit coordinators or supervisors which listed any residents that had gone three days without a bowel movement. The Unit Coordinator stated initially the reports were given to nurses on each	F 282	Care Area Assessments will be reviewed and revised quarterly to include problem area for resident at risk for constipation related to medications and history. Certified nursing assistants will be in-serviced upon hire and annually thereafter in the correct utilization of the electronic system to document bowel movements every shift for each resident. Daily reports containing resident-specific information detailing bowel movement frequency will be generated from electronic system by each unit manager. The daily reports indicate when resident has bowel movements and indicates warnings when resident has gone three days without a bowel movement. Each Unit Manager will provide the daily bowel movement tracking report to the charge nurse on each hall. Upon receipt of the daily bowel movement tracking report, the charge nurse will address any issues when the resident had gone three days without a bowel movement, sign the report and return it to the Unit Manager for verification. 3. A. The Interdisciplinary Care Planning Team involved in the assessment or care planning process has been in-serviced regarding developing and updating comprehensive care plans to establish	

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F 282	Continued From page 7 hall for them to initial the report had been reviewed and addressed. The Unit Coordinator stated the expectation was for nurses to determine if the problem was lack of nurse aide documentation or the need to implement PRN (as needed) medication orders related to an extended time without a bowel movement. The Unit Coordinator stated a couple weeks ago facility staff had decided the unit coordinators and supervisors needed to become more involved in the review process of these reports. The Unit Coordinator stated now licensed nurses were provided the report for the hall they were assigned and the report is supposed to be turned back in at the end of the shift (to the unit coordinator or supervisor). The Unit Coordinator stated part of their role was to review the returned reports to ensure any resident that went an extended time without a bowel movement had been addressed. The Unit Coordinator noted nothing had been documented on the 10/20/12 or 10/21/12 returned reports related to Resident #32 to indicate the extended time without a bowel movement had been addressed. The Unit Coordinator stated reports had not been turned back in on 10/22/12, 10/28/12 or 10/29/12. The Unit Coordinator noted bowel movements were not recorded on all shifts during these time frames and nurses should have asked the nurse aides if the resident had a bowel movement during their shift. The Unit Coordinator found the returned report sheet for 10/30/12 which indicated Resident #32 had been administered a Dulcolax suppository that morning and had a bowel movement later that day. The Unit Coordinator stated the licensed nurse that gave the Dulcolax suppository on	F 282	goals and determine interventions to address each resident's individual needs. The Director of Nursing or designee will audit head-to-toe assessments to ensure completion on every resident in-house and documented in the medical record on the Nursing Assessment form. The Director of Nursing or designee will audit 25% of resident records weekly to ensure a skin assessment was performed on each resident in-house by a licensed nurse and documented in the medical record on the Skin Assessment Form. The Director of Nursing will monitor the Skin Integrity Program on a weekly basis. The Director of Nursing will monitor weekly to ensure the Skin Integrity Nurse is providing monitoring of each Skin Assessment and coordination services to be provided to prevent skin breakdown and promote healing of areas of loss of skin integrity. The Director of Nursing or designee will audit each medical record upon admission to ensure an Assessment has been performed for each resident upon admission and weekly thereafter. The Director of Nursing or designee will audit the Skin Assessment log on a weekly basis as developed by the Skin Integrity Nurse.	

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F 282	Continued From page 8 10/30/12 told her she forgot to chart it on the October 2012 MAR of Resident #32. The Unit Coordinator could not explain why the "no bowel movement" reports were not available for all days or why there was no documentation to indicate the extended times without a bowel movement had been addressed for Resident #32.. On 11/08/12 at 5:55 PM the Director of Nursing (DON) stated her expectation regarding bowel monitoring was for the unit coordinators to review the "no bowel movement" reports on a daily basis to ensure nursing staff were addressing any residents that had gone three days without a bowel movement. The DON stated she expected unit coordinators to inform nurses on the hall which of their residents needed to be looked at to determine 1) if they needed to talk to the nurse aides if nothing had been recorded during their shift to see if the resident did have a bowel movement 2) use any PRN medications ordered for constipation for the individual resident and/or 3) call the resident's physician to ask for something to treat constipation (noting the facility does not have standing orders).	F 282	The Skin Integrity Nurse will maintain a log to identify each skin assessment form and include the determination of those residents needing further intervention or referral to our wound care physician for a specific treatment regimen. The Director of Nursing or designee will audit care plans on a quarterly basis to ensure each resident identified upon admission or during weekly skin assessments who has a loss of skin integrity has their care plan reviewed and revised as needed. The Director of Nursing or designee will monitor each Working Plan of Care monthly to ensure the interventions have been placed on the Working Plan of Care. B. The Director of Nursing or designee will audit Working Plan of Cares on a monthly basis to ensure each resident with incontinence or propensity to constipation has been reassessed and their Working Plan of Care has been updated to include specific interventions to address incontinence, bowel movement monitoring and treatment of constipation. The Director of Nursing or designee will audit each Interdisciplinary Care Plan quarterly to ensure the care plan has been reviewed and revised to ensure resident needs related to incontinence, need for bowel movement monitoring and treatment for constipation are addressed.	
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 medical record review, observations	F 312		

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F 312	Continued From page 9 and interviews the facility failed to provide services to 1 of 1 dependent residents to prevent nail to skin contact. (Resident #105). The findings are: Resident #105 was admitted to the facility 10/30/09 and readmitted 04/14/10 with diagnoses which included osteoarthrosis, muscle weakness, anemia, delirium and schizophrenia. Resident #105 had been under hospice services since 04/23/10. The current Minimum Data Set (MDS) assessment dated 08/27/12 for Resident #105 noted Resident #105 had significant cognitive impairment, was dependent on at least one person for personal hygiene and bathing. The current care plan dated 09/10/12 included the problem areas: 1. Potential for impaired skin integrity related to impaired bed mobility, incontinence of bowel and bladder and risk for skin breakdown. Approaches to address this problem included: *Weekly skin checks *Report any red or open areas 2. Self care deficit related to dementia and schizophrenia Approaches to address this problem included: *Physical therapy/Occupation therapy as needed *Examine skin during bathing for signs/symptoms of irritation or breakdown. Document and report as needed Observations and staff interviews were made of Resident #105 during the survey	F 312	The Director of Nursing or designee will audit each MDS Comprehensive Assessments has been reviewed quarterly to ensure resident status is consistent with nursing assessments and documentation. The Director of Nursing or designee will audit Care Area Assessments quarterly to ensure the CAA has been reviewed and revised quarterly to include problem area for resident at risk for constipation related to medications and history. Licensed nurses and Certified nursing assistants will be re-educated upon hire and annually thereafter in the correct utilization of the electronic system to document bowel movements every shift for each resident. The Director of Nursing or designee will monitor daily reports containing resident-specific information detailing bowel movement frequency which are generated from electronic system by each unit manager. The daily reports indicate when resident has bowel movements and indicates warnings when resident has gone three days without a bowel movement. The Director of Nursing or designee will monitor the Working Plan of Care monthly to ensure the Interventions have been placed on the Working Plan of Care.	

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F 312	Continued From page 10 11/05/12-11/09/12. These observations and interviews included: 11/05/12 12:00 PM Resident #105 was observed in bed. The resident's left hand was covered with a blanket and her right hand had a palm guard in place.. 11/05/12 3:57 PM Resident #105 was observed in bed. The resident's left hand was observed with her fingers drawn in, toward her palm. The nails on her left hand were long and jagged and extended beyond the end of her finger. A "carrot" (a small padded cloth device in the shape of a carrot used to prevent nail to skin contact when placed in the palm of a resident's hand) was observed on the resident's bedside table. 11/06/12 10:20 AM Resident #105 was observed in bed. The resident's left hand was observed with her fingers drawn in, toward her palm. The nails on her left hand were long and jagged and extended beyond the end of her finger. 11/06/12 5:00 PM Resident #105 was observed in bed. The resident's left hand was laying on a pillow. The resident's fingers on her left hand were drawn in, toward her palm. The nails on her left hand were long and jagged and extended beyond the end of her finger. A "carrot" was observed on the resident's bedside table. 11/07/12 9:00 AM Resident #105 was observed in bed. The resident's left hand was laying on a pillow. The resident's fingers on her left hand were drawn in, toward her palm. The nails on her left hand were long and jagged and extended beyond the end of her finger. A "carrot" was	F 312	4. The Director of Nursing or designee will audit documentation in each resident's medical record to ensure skin assessments and bowel monitoring care plans are followed and documented and will report to the Quality Assurance Committee on a monthly basis x 3 months, then quarterly thereafter to ensure resident's care plans, assessments and treatment plan for each resident with loss of skin integrity and issues related to bowel movement monitoring and treatment for constipation meet each individual resident's needs. F 312 1. Resident #105 was provided hygiene and nail care during the survey. The Interdisciplinary Care Plan and Working Plan of Care for resident #105 were updated to include ADL assistance to promote hygiene of her left hand, nail care and proper utilization of the carrot in her left hand to prevent contractures and nail to skin contact. Education and communication between Hospice Nurse Aide and facility Certified Nursing Assistants was provided to ensure continuous and consistent nail care and use of carrot device in palm of left hand of resident #105. A physician's order was obtained to have "carrot" in place in left hand of resident #105.	12-7-12

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F 312	Continued From page 11 observed on the resident's bedside table. 11/07/12 11:00 AM An observation was made with the Unit Coordinator (over the unit Resident #105 resided). A palm guard was observed in place on the resident's right hand. The resident's left hand was propped on a pillow. The resident's thumb nail on her left hand extended approximately 1/8" beyond the end of her finger. The resident's thumb nail was embedded in the middle knuckle of the resident's third finger. Resident #105 did not appear able to freely move her thumb finger so the unit coordinator gently moved the thumb from the third finger and an indention was noted on the third finger where the resident's thumb had been positioned. The resident's nail on the second finger was noted to be jagged and long and extended approximately 1/8" from the end of the finger. The resident's second finger was drawn in, toward the palm of her hand. The resident's fourth finger had a band-aid over the nail bed and the finger was drawn inward, toward the palm of her hand. The Unit Coordinator stated Resident #105 was under Hospice services and between Hospice, facility nurse aides and nurses, her nails should be kept trimmed. The "carrot" was observed on the bedside table and the Unit Coordinator stated she was not sure whether it was supposed to be used for Resident #105. 11/07/12 11:17 AM Resident #105 was observed in bed. The resident's thumb nail on her left hand was embedded in the middle knuckle of the resident's third finger. The resident's thumb nail was long and jagged and extended approximately 1/8" beyond the end of her finger. A "carrot" was observed on the resident's bedside table.	F 312	2. Each resident in the facility has been evaluated from head-to-toe, to include potential for contractures, need for nail care and possibility of nail-to-skin contact. Interdisciplinary Care Plans and Working Plan of Cares have been updated as indicated to include interventions to prevent and address nail-to-skin contact, as well as need for assistance with nail hygiene. 3. All licensed nurses and Certified Nursing Assistants have been re-educated regarding the need to provide ADL assistance and devices to prevent nail to skin contact. Charge nurses will be responsible for monitoring ADL and hygiene assistance provided by Certified Nursing Assistants to ensure proper nail care is provided and proper application of devices to prevent nail to skin contact. Communication developed and enhanced between Hospice care providers and facility caregivers to ensure resident needs are met regardless of which discipline is primarily and routinely providing nail care and utilization of devices to prevent nail to skin contact to each resident. Charge Nurses and Unit managers will monitor ADL documentation in electronic charting system to ensure ADL, provision	

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F 312	Continued From page 12 11/07/12 12:17 PM An observation was made of Resident #105 along with Nurse #7. Nurse #7 stated she was familiar with Resident #105 and worked with the resident three days a week. Nurse #7 stated the nurse aide with Hospice services provided nail care. Nurse #7 noted the palm guard in place on the resident's right hand. The resident's right finger was wrapped around the front of the palm guard and the nail was extended approximately 1/4" from the end of the finger. Nurse #7 observed the "carrot" on the bedside table and indicated the "carrot" was given to all Hospice residents for comfort. Nurse #7 stated there were no physician orders for Resident #105 to have the "carrot" in place. Nurse #7 did note she used to place the "carrot" in the left hand of Resident #105 during a prior time that she resided on the unit (Resident #105 had moved to the room she was in on 10/10/12). The resident's thumb nail on her left hand was observed extended approximately 1/8" beyond the end of her finger. The resident's thumb nail was embedded in the middle knuckle of the resident's third finger. Nurse #7 easily placed the "carrot" (from the bedside table) in the resident's left hand which prevented the left thumb nail from embedding into the third finger. 11/07/12 2:00 PM The Unit Coordinator stated she understood the concern of the potential of problems with Resident #105's left hand due to nail to skin contact. The Unit Coordinator stated she was going to have the Occupational Therapist look at the resident's left hand.. 11/07/12 2:30 PM A Nurse Aide (NA) with Hospice services reported she had worked with	F 312	of nail care and use of devices is provided and documented. Unit manager and Director of Nursing or designee will conduct observation rounds on a daily basis to evaluate condition of resident's hands and nails and proper use of carrots and other devices to prevent contact between nails and skin. 4. The Unit Managers will monitor on a weekly basis to ensure the proper utilization of devices and nail care to prevent nail to skin contact. The Director of Nursing or designee will monitor on a monthly basis the use of devices and nail care to prevent nail to skin contact. The Director of Nursing or designee will audit ADL reports on a monthly basis from the electronic documentation system to ensure hygiene and ADL assistance are charted regularly by the Certified Nursing Assistants. The audit tools and data collection from monitoring from rounds will be reviewed and monitored monthly by the Quality Assurance Committee.	12-7-12

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F 312	Continued From page 13 Resident #105 for approximately 18 months. The Hospice NA stated she provided activity of daily living (ADL) care during her visits which included nail care. The Hospice NA noted the resident's range of motion in her left hand had become progressively worse over the past 15 months. The Hospice NA stated she had 'dropped the ball' on keeping Resident #105's nails cut. The Hospice NA stated Resident #105 wore a palm guard in her right hand but had never seen anything in the resident's left hand. The Hospice NA stated she just finished cutting all but one of Resident #105's fingernails. The Hospice NA stated there was one nail on the resident's right hand she was not able to cut due to the finger being so contracted. The Hospice NA stated that she tried to collaborate care with the facility's NAs to ensure the resident's well being. 11/07/12 3:15 PM Resident #105 was observed in bed. The 'carrot" remained in the resident's left hand. The resident's fingernails on her left hand were trimmed back to the end of the finger. 11/07/12 4:00 PM The Hospice Nurse familiar with Resident #105 stated the resident's left hand had gotten more contracted the past couple months. The Hospice Nurse stated at times Resident #105 would resist when attempts were made to clean her hand or put a cloth in the hand to prevent nail to skin contact. The Hospice Nurse stated "carrots" are provided to all residents with contractures to prevent nail to skin contact. The Hospice Nurse stated there were no orders for the "carrot" to be used for Resident #105 but she was going to have an evaluation done by the Occupational Therapist. The	F 312		

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F 312	Continued From page 14	F 312		

Hospice Nurse reviewed her notes in the Hospice electronic record and stated in August 2012 she noted the resident's left hand was getting more contracted. The Hospice Nurse stated Resident #105's left hand was initially hard to open and that it had gotten progressively worse noting the resident had pain when her fingers were manipulated. The Hospice Nurse stated in September 2012 the resident's middle finger was noted to appear to be more fixed in place.

11/08/12 11:40 AM and 1:11 PM Resident #105 was observed in bed. A palm guard was in place on her left hand which prevented nail to skin contact. The resident's nails on her left hand were trimmed back to the end of the finger.

11/08/12 1:20 PM The Occupational Therapist (OTR) stated a palm guard had been placed in the left hand of Resident #105. The OTR stated she soaked the resident's left hand in warm water and applied lotion to relax her hand. The OTR stated she placed the palm guard in the resident's left hand to prevent nail to skin contact. The OTR stated rigidity in the resident's hands caused her fingers to draw inward, toward her palm.

11/08/12 2:30 PM The OTR was observed in the room with Resident #105. The OTR stated she wanted to check the resident's left hand to determine her tolerance to the palm guard. The OTR easily removed the palm guard from the resident's left hand and replaced it after assessing the hand. The therapist commented the palm guard appeared to be beneficial in preventing nail to skin contact.

11/08/12 5:00 PM Nurse Aide #1 (NA) stated she

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F 312	Continued From page 15 was very familiar with Resident #105. NA #1 stated Resident #105 had palm guards in place on both hands. NA #1 stated a couple weeks ago she took both palm guards to the laundry because they were so badly soiled. NA #1 stated the resident's right hand palm guard was the only one that was returned from the laundry. NA #1 stated she used to use the "carrot" or a washcloth in the resident's hands to prevent skin to skin contact. NA #1 stated last week she attempted to cut Resident #105's nails but the resident was resistive to care. NA #1 stated nail care was provided by facility and Hospice nurse aides and they tried to keep her nails trimmed because of how the resident clenched her hands. . 11/08/12 5:45 PM The facility Director of Nursing (DON) stated she expected any resident needs to be addressed daily at the stand up meetings. The DON stated she expected nurse aides, nurses, rehab staff, the unit coordinators and Hospice to be in communication with each other and to share any needs of residents. The DON stated there should be measures in place to prevent nail to skin contact for residents. On 11/08/12 a physician's order was written to "Please use hand guards to prevent injury to palms due to hand contractures/voluntary hand clenching". 110/9/12 9:30 AM The Unit Coordinator stated since Resident #105 moved to her unit on 10/10/12 she had not seen a palm guard in the resident's left hand. The Unit Coordinator stated a palm guard would be a need placed on a resident's care guide (a communication tool used by nursing assistants to know individual needs of	F 312		

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F 312	Continued From page 16 residents). The Unit Coordinator stated that nurses or unit coordinators were responsible for updating resident care guides as needs changed. The care guide for Resident #105 was reviewed and indicated that nail care was to be done "by staff". The care guide did not address the need for any devices (i.e. palm guard, "carrot", washcloth) in the resident's hands.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to complete weekly skin assessments and failed to notify the physician of skin breakdown for 2 days in 1 of 4 sampled residents at risk for skin breakdown (Resident #113). The findings are:	F 314	1. Resident #113 has been reassessed and care plan has been updated to include specific interventions to address skin integrity. A head-to-toe assessment has been completed on resident #113 and documented in the medical record on the Nursing Assessment form. A skin assessment was performed by a licensed nurse and documented in the medical record on the Skin Assessment Form. Assessment of resident #113 will be performed by a licensed nurse will be completed weekly and documented in the medical record on the Weekly Skin Assessment form Licensed nurses have been re-educated regarding the need to notify any resident's physician, including Resident #113, when there is skin breakdown.	

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F 314	Continued From page 17 Resident #113 was admitted to the facility with diagnoses including malnutrition and aftercare joint replacement. An admission Minimum Data Set (MDS) dated 09/15/12 revealed Resident #113 was understood, understands and able to make her needs known. The MDS also revealed Resident #113 was at risk for developing pressure ulcers which triggered for a care area assessment and care plan development. Review of a nursing care plan dated 09/08/12 indicated Resident #113 was at potential risk for skin breakdown related to immobility and weakness from recent hospitalizations. The documented goal was for resident to remain free from tissue injury through preventative nursing measures through next review of 12/06/12. Interventions in place included; assess skin weekly per facility protocol, notify nurse and physician of any new areas noted, and exercise caution during transfers and handling as skin is fragile. An admission nursing assessment was completed on 09/08/12 which included a skin condition assessment. The skin assessment described an area on Resident #113's left hip as warm, reddened, dry skin with edema. In the comments section, documentation revealed; "see nurse's notes for details." Review of a nurse's note dated 09/08/12 revealed Resident #113 had "multiple skin issues" and "skin is dry and flaky everywhere." The nurse's note further revealed a "quarter size blood blister" behind the resident's right knee, buttocks appeared excoriated and the presence of a rash on the resident's back and neck.	F 314	2. A head-to-toe assessment has been completed on every resident in-house and documented in the medical record on the Nursing Assessment form. A skin assessment was performed on each resident in-house by a licensed nurse and documented in the medical record on the Skin Assessment Form. A Skin Integrity Program has been developed which is coordinated by a Skin Integrity Nurse. The Skin Integrity Nurse will provide monitoring of each Skin Assessment and will coordinate services to be provided to prevent skin breakdown and promote healing of areas of loss of skin integrity. An Assessment will be performed for each resident upon admission and weekly thereafter. The Skin Assessment form will be placed in the Skin Integrity Nurse's file. She will evaluate each assessment and determine which residents need further intervention or referral to our wound care physician for a specific treatment regimen. The Skin Integrity Nurse will place the Skin Assessment form in each resident's medical record. Each resident identified upon admission or during weekly skin assessments who has a loss of skin integrity will have their care plan reviewed and revised as needed. The interventions will be placed on the Working Plan of Care in addition to the Interdisciplinary Comprehensive Care Plan.	

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F 314	Continued From page 18 Review of a nurse's note dated 11/02/12 at 6:00 PM revealed Resident #113 had a new area of skin breakdown on upper left buttocks approximately 2 centimeters (cm) by 3 cm with undeterminable depth. Review of a "Weekly Skin Assessment" dated 11/07/12 revealed Resident #113 had an open area located on the right inner buttock, an open area located on the left lower leg and a scratch on the left upper hip. Further review of Resident #113's medical record did not reveal any other weekly skin assessments. On 11/08/12 at 2:30 PM an observation was made of Nurse #3 assessing a new area of skin breakdown on Resident #113. An open area, 0.8 cm by 2.5 cm, was noted on the resident's right inner buttock with a small amount of slough. Nurse #3 indicated this was a Stage 2 pressure ulcer (partial thickness skin loss). An interview was conducted on 11/08/12 at 2:45 PM with Nurse #4 who documented in the nurses notes on 11/02/12 regarding Resident #113's skin breakdown. Nurse #4 revealed Resident #113 complained of pain and on assessment noted the new area of skin breakdown and notified the Nurse Supervisor (Nurse #5). Nurse #4 further revealed she did not notify the physician. Nurse #5 was interviewed 11/08/12 at 3:00 PM and revealed she told Nurse #4 to call the physician to get an order for treatment. Nurse #5 further revealed she did not recall if she assessed Resident #113 or followed up with Nurse #4 contacting the physician.	F 314	The Charge Nurse will be responsible for notifying resident's physician when there is skin breakdown. 3. The Skin Integrity Nurse will monitor each skin assessment and will provide additional monitoring to ensure resident's physician is notified of skin breakdown. The Director of Nursing or designee will audit head-to-toe assessments to ensure completion on every resident in-house and documented in the medical record on the Nursing Assessment form. The Director of Nursing or designee will audit 25% of resident records weekly to ensure a skin assessment was performed on each resident in-house by a licensed nurse and documented in the medical record on the Skin Assessment Form. The Director of Nursing/designee will monitor the Skin Integrity Program on a weekly basis. The Director of Nursing/designee will monitor weekly to ensure the Skin Integrity Nurse is providing monitoring of each Skin Assessment and coordination services to be provided to prevent skin breakdown and promote healing of areas of loss of skin integrity. The Director of Nursing or designee will audit each medical record upon admission to ensure an Assessment has been performed for each resident upon admission and weekly thereafter.	

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F 314	Continued From page 19 An interview on 11/08/12 at 4:57 PM with the facility Nurse Practitioner (NP) revealed she was not aware of Resident #113's area of skin breakdown of 11/02/12 until 11/04/12 when she was notified verbally and also revealed there was no communication in the physician's communication book. The NP revealed she ordered a moisture retentive dressing and indicated she should have been notified of the skin breakdown on 11/02/12. The NP further indicated she was notified of the area of skin breakdown of 11/07/12 and ordered a medicated ointment for the area on Resident #113's right inner buttock. The NP indicated the area of breakdown could be a result of pressure and moisture. An interview with the Director of Nursing (DON) on 11/08/12 at 5:55 PM revealed the nurse who finds an area of skin breakdown on a resident is responsible for notifying both the unit manager or nurse supervisor and the physician to obtain orders. The DON also revealed the unit manager or nurse supervisor should follow up with the nurse to make sure the physician was notified. The DON further revealed the physician should have been notified on 11/02/12 when the area of breakdown was first noted on Resident #113's upper left buttock.	F 314	The Skin Integrity Nurse will maintain a log to identify each skin assessment form and include the determination of those residents needing further intervention or referral to our wound care physician for a specific treatment regimen. The Director of Nursing or designee will audit the Skin Assessment log on a weekly basis as developed by the Skin Integrity Nurse. The Director of Nursing or designee will audit care plans on a quarterly basis to ensure each resident identified upon admission or during weekly skin assessments who has a loss of skin integrity has their care plan reviewed and revised as needed. The Director of Nursing or designee will monitor each Working Plan of Care monthly to ensure the interventions have been placed on the Working Plan of Care. 4. The Director of Nursing or designee will audit documentation in each resident's medical record on a quarterly basis to ensure skin assessments and bowel monitoring care plans are followed and documented and will report to the Quality Assurance Committee on a monthly basis x 3 months, then quarterly thereafter to ensure resident's care plans, assessments and treatment plan for each resident with loss of skin integrity and issues related to bowel movement monitoring and treatment for constipation meet each individual resident's needs.	12-7-12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315		

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F 315	Continued From page 20 catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to provide medical justification for the use of an indwelling urinary catheter for 1 of 3 sampled residents with catheters. (Resident #113). The findings are: Resident #113 was admitted to the facility with diagnoses including malnutrition and aftercare joint replacement. An admission Minimum Data Set (MDS) dated 09/15/12 revealed Resident #113 was understood, understands and able to make her needs known. The MDS further revealed Resident #113 had an indwelling urinary catheter. Review of physician orders for Resident #113 revealed there was not a physician order for the indwelling urinary catheter. A review of Resident #113's medical record revealed there was not a specific diagnoses related to the use of the indwelling urinary catheter. Review of the Interim Plan of Care dated 09/09/12 indicated log roll only and do not get out of bed for 3 days.	F 315	1. The indwelling urinary catheter was removed from Resident #113 during the survey. Resident #113 was reassessed and her Interdisciplinary Care Plan and Working Plan of Care were updated to reflect resident's urinary continence. 2. Each resident with urinary incontinence, the potential for an indwelling urinary catheter or admitted with an indwelling urinary catheter will be evaluated for appropriateness of the catheter within 72 hours of admission. Justification for an indwelling urinary catheter will be clarified by the resident's physician and documented in the medical record. Each resident with an indwelling urinary catheter will have justification for the catheter in the Working Plan of Care and the Interdisciplinary Care Plan. 3. All licensed nurses have been re-educated regarding justification for indwelling urinary catheter usage, need for physician's order and documented diagnosis to support the use of an indwelling catheter.	

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	345493	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSONVILLE HEALTH AND REHABILITATION	104 COLLEGE DRIVE FLAT ROCK, NC 28731

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F 315	Continued From page 21 An interview with the facility's Nurse Practitioner (NP) on 11/07/12 at 10:50 AM revealed Resident #113 had an infected surgical wound from recent hip surgery and thought she may have had some urinary retention. After reviewing Resident #113's medical record, the NP revealed she was unable to find a documented reason for the indwelling urinary catheter. An interview with Resident #113 on 11/07/12 at 11:00 AM revealed the indwelling urinary catheter was placed during her last hospitalization prior to her admission to the facility. Resident #113 revealed she did not know why she had the catheter and indicated she had never had a problem emptying her bladder. Resident #113 further revealed she would like to have the catheter removed so she could be more mobile. The Director of Nursing (DON) was interviewed on 11/07/12 at 2:30 PM. The DON revealed Resident #113 was admitted to the facility for therapy after hip surgery. The DON revealed the orthopedic physician requested no therapy for 3 days, do not get out of bed for 3 days and log roll to have bandages changed only, and thought the indwelling catheter was in place for the above stated reasons.	F 315	The Interdisciplinary Care Planning Team involved in the assessment or care planning process has been in-serviced regarding monitoring to ensure comprehensive care plans include justification for the use of an indwelling urinary catheter. 4. The Director of Nursing or designee will monitor the usage and justification of each resident with an indwelling urinary catheter on a monthly basis. The Director of Nursing or designee will monitor the usage and justification of each resident with an indwelling urinary catheter on a monthly basis and will report to the Quality Assurance Committee on a monthly basis x 3 months, then quarterly thereafter to ensure compliance with documenting justification for each indwelling urinary catheter in the medical record.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in	F 412	1. The MDS for resident #187 has been reviewed and updated to ensure accuracy related to the condition and proper fit of his dentures. Resident #187 has been evaluated by a dentist and has received new properly fitting dentures.	

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F 412	Continued From page 22 making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed to provide dental services as ordered by the physician for 1 of 1 sampled resident reviewed for dental needs. (Resident #187). The findings are: Resident #187 was admitted to the facility with diagnoses including nausea, vomiting, diarrhea, fatigue, and dehydration. The latest Minimum Data Set (MDS) dated 10/09/12 specified the resident's cognition was intact. The MDS also described the resident's dentures as loose fitting. A review of Resident #187's medical record revealed a physician's order dated 08/19/12. The order specified to obtain a dental consult for the resident due to poorly fitting dentures and a sore mouth. Nurse #2's name was written on the physician's order slip as the nurse receiving the order. A review of a nutritional care plan for Resident #187 was conducted. The care plan updated 10/15/12 indicated the resident had a potential for weight loss related to 25% or more of food uneaten at most meals. The care plan goal specified the resident would maintain current weight for the next 90 days. An intervention	F 412	Resident #187 has been reassessed and his nutritional care plan has been updated to reflect his dental and nutritional needs. Audit of medical record subsequent to survey for resident #187 confirms that all physician orders have been followed. 2. All residents with dentures have been assessed for proper fit. All licensed nurses have been re-educated regarding the proper completion and transmittal of the Appointment /Transportation Communication Sheet to the appointment scheduler. Unit Managers are responsible for monitoring physician orders on a daily basis to ensure appointments are communicated to the appointment scheduler. 3. The Director of Nursing or designee will audit physician orders and Communication Sheets on a weekly basis to ensure the need for appointments or referrals are communicated to the Scheduler. 4. The Director of Nursing will report to the Quality Assurance Committee quarterly regarding compliance with physician's orders for scheduling of appointments and communication to the scheduler for residents needing appointments or transportation.	12-7-12

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F 412	Continued From page 23	F 412		

added to the care plan on 10/15/12 contained instructions to assist the resident with denture adhesive. The intervention also instructed the nursing staff to encourage Resident #187 to wear dentures in order to chew his food.

An interview was conducted with Resident #187 on 11/06/12 at 9:25 AM. The resident was observed at this time to have his upper dentures in place. As he attempted to talk, the dentures were observed to fall away from his gums prohibiting clear speech. He would push his dentures back into place and would have to close his mouth to keep the dentures from falling out. Resident #187 stated he would like for his dentures to be fixed. He added the facility does provide food he can chew.

An interview with Nurse #1 was conducted on 11/07/12 at 10:30 AM. She stated facility protocol for a physician's order requiring an appointment for a resident was for an Appointment / Transportation Communication Sheet to be filled out. Nurse #1 stated this sheet should be sent to the Scheduler who makes appointments for residents.

An interview with the Scheduler on 11/07/12 at 10:40 AM revealed she never received the Appointment / Transportation Communication Sheet for Resident #187 to have a dental consult.

An interview with the Director of Nursing on 11/07/12 at 10:45 AM revealed she expected physician orders were carried out per facility protocol.

An interview via phone was conducted with Nurse

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F 412	Continued From page 24 #2 on 11/07/12 at 2:28 PM. She stated she does not remember carrying through with the physician's order for Resident #187 to have a dental consult. She added she can not say why she did not fill out the proper communication for the scheduler. Continued interview with Resident #187 on 11/07/12 at 4:15 PM revealed he did not have his dentures in at this time because his gums were too sore to wear them.	F 412		