STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #TCDS11.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed	F 636		4/27/18

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

Electronically Signed | 04/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 636	Continued From page 1 on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Care Area Assessments accurately and comprehensively that address underlying causes and contributing factors for the triggered areas for 2 of 22 sampled residents. (Residents #32 and #34). The findings included: 1. Resident #32 was admitted to the facility on 04/26/12 with diagnoses included dementia, heart failure, depression and delusional disorders.	F 636	1. Facility staff failed to accurately address the nature of resident #32's condition, the presence of causes and contributing factors related to the care area. Cognitive status was reassessed and care plan was revised by MDS nurses on 4/5/18. 2. Facility staff failed to accurately address the nature of resident #34's condition, the presence of causes and contributing factors related to the care area. Psychotropic medication was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 636	Continued From page 2 The most recent comprehensive Minimum Data Set (MDS) dated 02/11/18 coded Resident #32 with severely impaired cognition and moderate difficulty in hearing. She required extensive staff assistance with 1 to 2 + persons physical assist for most activities of daily living (ADL) and supervision with eating. Cognitive loss/dementia was one of the care areas that triggered for further staff review. Review of the Care Area Assessment (CAA) worksheet for cognitive loss/dementia dated 10/21/17 provided a check list that documented Resident #32's neurological factors, observable characteristics and extent of Resident #32's cognitive loss, medical problems affected cognition, and the relationship of pain and functional status to cognitive loss. Other considerations checked on the CAA that could affect Resident #32's ability to process information included hearing impairment. There was little or no explanation of the issues checked. Other than a list of diagnoses, the CAA did not contain an analysis addressing the nature of Resident #32's condition, the presence of causes and contributing factors, risk factors related to the care area, and the reasons for a decision to proceed with care planning for cognitive status. An interview was conducted with the Director of Social Services on 04/06/18 at 9:29 AM. She acknowledged that she was responsible for the completion of Resident #32's CAA in the area of dementia for the MDS dated 10/21/17. She added there were many CAAs needed to be updated when she was working on Resident #32's CAA for dementia in late October 2017. She stated that the CAA, especially the analysis of findings was	F 636	reassessed and care plan was revised by MDS nurses on 4/5/18. 3. All other residents have the potential to be affected. 100% of all active residents with completed comprehensive assessments will be audited to ensure that the CAA process includes contributing factors and underlying causes. Care plans will be revised as needed. This will be completed by MDS nurses by 5/4/18. 4. 100% of the comprehensive assessments will be audited for comprehensive CAA documentation weekly times 4 weeks and then monthly times two months. The first weekly audit was completed by 4/20/18. The last monthly MDS nurse audit will be completed by 7/10/18. 5. The interdisciplinary team involved in the CAA process which includes the social worker, activity director, dietary manager and MDS nurses will be educated on the CAA process by 4/26/18. This education will be presented by the MDS Coordinator. 6. All findings will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing and/or the MDS Coordinator for compliance times 3 months and re-evaluate for on-going compliance thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 636	Continued From page 3	F 636		

incomplete and incomprehensive without description of the problem, causes and contributing factors, risk factors, and reasons to proceed with care planning.

On 04/06/18 at 11:59 AM an interview was conducted with the Director of Nursing. She stated it was her expectation that all CAA assessments must be individualized and being completed accurately and comprehensively.

2. Resident #34 was admitted to the facility on 01/22/17 with diagnoses included dementia, heart failure, diabetes mellitus, and depression.

The most recent comprehensive MDS dated 02/05/18 coded Resident #34 with intact cognition. He required supervision to extensive assistance with setup to 1 person physical assist for most ADL and supervision with eating. The MDS further indicated Resident #34 was on antianxiety and antidepressant daily on the 7-days look back period. Psychotropic medication use was one of the care areas that triggered for further staff review.

Review of the CAA worksheet for psychotropic medication use dated 02/05/18 provided a check list that documented Resident #34's classes of medication currently taking, treatable medical conditions, and adverse consequences of antidepressant and antianxiety exhibited by Resident #34. There was little or no explanation of the issues checked. Other than stating: "Resident requests the use of side rails to promote mobility. Resident refuses alternative measures", the CAA did not contain an analysis addressing the nature of Resident #34's condition, the presence of causes and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 636	Continued From page 4	F 636		

contributing factors, risk factors related to the care area, and the reasons for a decision to proceed with care planning for psychotropic medication use.

An interview was conducted with the Nurse #1 who was also the MDS Coordinator on 04/05/18 at 3:05 PM. She acknowledged that she was responsible for the completion of Resident #34's CAA in the area of psychotropic medication use for the MDS dated 02/05/18. She added the CAA for Resident #34's psychotropic medication use was supposed to be for CAA in physical restraints. She agreed that the CAA was inaccurate and incomprehensive without description of the problem, causes and contributing factors, risk factors, and reasons to proceed with care planning.

Review of the CAA worksheet for physical restraints dated 02/05/18 revealed the CAA was inaccurate and incomprehensive without an analysis addressing the nature of the problem, causes and contributing factors, risk factors, and reasons to proceed with care planning.

In a subsequent interview conducted with Nurse #1 on 04/06/18 at 9:00 AM, she stated even though Resident #34 was diagnosed with anxiety and depression, he did not show any symptoms and there were no other contributing factors. However, she did not include those information in the analysis.

On 04/06/18 at 11:59 AM an interview was conducted with the Director of Nursing. She stated it was her expectation that all CAA assessments must be individualized and being completed accurately and comprehensively.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code obvious cavities and broken teeth on the admission assessment (Resident #274) for 1 of 1 resident reviewed for dental and failed to accurately code the correct number and stage of pressure ulcers on the admission assessment (Resident #66) for 1 of 3 residents reviewed for pressure ulcers. Findings included: 1. Resident #274 was admitted to the facility 06/14/17 with diagnoses including cerebrovascular accident and heart failure. A record review of the most recent admission Minimum Data Set (MDS) dated 06/21/17 revealed section L0200/Dental was coded as none of the above indicating Resident #274 had no obvious cavities or broken teeth. A review of the Care Area Assessment (CAA) section of the MDS revealed the resident had dental caries and an abscess present and was receiving pain and antibiotic medication. The CAA analysis of findings describes Resident #274 as having poor oral hygiene with several caries in her existing teeth and abscess that was being treated. During an observation on 04/02/18 at 3:59 PM, Resident #274 revealed several broken teeth. There were multiple teeth with brown and black areas.	F 641	1. Resident #274 for section L was coded incorrectly. Section L was coded none of the above. Section L was modified on 4/6/18 and coding was corrected by the MDS nurse. 2. Resident #66 for section M was coded incorrectly. Resident's current pressure ulcers were as follows: 2 stage one, 2 stage two and 1 unstageable. The MDS was modified and corrected on 4/6/18 by the MDS nurse. 3. All other residents have the potential to be affected. 100% of all active residents' last completed assessment will be audited for accuracy of sections L and M. MDS nurses will complete the dental assessment on all MDS assessments by performing an in person visual assessment. The audit will be completed by the MDS nurses by 4/27/18. 4. 50% of the assessments completed weekly will be audited by the MDS nurses for accuracy of sections L and M times 4 weeks then monthly times 2 months. The first audit was completed by 4/20/18 and the last audit will be completed by 7/10/18. 5. The MDS nurses will complete the sections L and M education on Health Care Academy by 4/26/18. 6. All findings will be reported to the Quality Assurance Performance	4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 641	Continued From page 6 During an interview on 04/06/18 at 3:33 PM, the MDS Coordinator revealed she completed section L0200/Dental assessment for Resident #274 and coded none of the above. She revealed no visual assessment or resident interview was done by her to the provide the information used to code L0200/Dental. She explained the information used to complete section L0200/Dental was obtained from a admission nursing assesment. She confirmed the MDS was incorrectly coded and should've been coded to show there were cavities and broken natural teeth and explained a modification would be done. During an interview on 4/06/18 at 12:32 PM, the Administrator explained his expectations were for the MDS to be correctly coded for residents. 2. Resident #66 was admitted to the facility 03/07/18 with diagnoses including diabetes mellitus and multiple drug resistant organism. A record review of the most recent admission Minimum Data Set (MDS) dated 03/19/18, section M/skin conditions was used to determine the number and stage (minor reddening of the skin to severe tissue damage) of unhealed pressure ulcers indicated: · One stage 1 · Two stage 2 · One stage 4 · One unstageable A review of the wound nurse assessment notes dated 03/13/18 indicated Resident #66 had the following number and stage of pressure ulcers during the assessment period: · Two stage 1	F 641	Committee by the Director of Nursing and/or the MDS Coordinator for compliance times 3 months and then re-evaluate for on-going compliance thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 641	Continued From page 7 · Two stage 2 · One unstageable During an interview on 04/05/18 at 10:37 AM, the MDS Coordinator explained she is provided a report of all the wounds in the facility and uses the report to document section M/skin conditions. Upon reviewing the wound report, she confirmed there were (2) stage 1 pressure ulcers and no stage 4 documented. She confirmed the admission MDS section M/skin condition was incorrectly coded and she would modify the assessment to show the correct number and stage of pressure ulcers. During an interveiw on 4/06/18 at 12:32 PM, the Administrator explained his expectations were for the MDS to be correctly coded for residents.	F 641		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (ii) A resident who enters the facility with an	F 690		4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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	Continued From page 8 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 (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. §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, resident and staff interviews, the facility failed to prevent a urinary drainage bag and tubing from touching the floor for 1 of 2 residents reviewed for urinary catheters (Resident #65). The findings included: Resident #65 was admitted to the facility on 04/04/18 with diagnoses including obstructive uropathy. The 5-day admission Minimum Data Set (MDS) dated 03/11/18 indicated Resident #65 was alert and oriented. The MDS also indicated Resident #65 required extensive assist with transfers, hygiene and toileting. The MDS further indicated Resident #65 had an indwelling catheter. Record review of the care plan dated for 03/17/18 indicated Resident #65 was at risk for developing	F 690	1. Resident #65 was observed from 4/2/18 until 4/5/18 sitting in a wheelchair or recliner with his indwelling catheter tubing and bag touching the floor. Privacy bag was intact. Resident #65's catheter bag was changed to a leg bag per resident request on 4/5/18. The tubing was immediately changed after being contaminated. 2. The process for indwelling catheters is as follows: assure indwelling catheter is medically necessary; hand washing before and after care; daily catheter care should include changing drainage tubing as necessary and change tubing if it becomes contaminated; check urine for appearance; urinary bag must be held lower than bladder at all times to prevent urine in tubing and drainage bag from flowing back into bladder. Check to make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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	Continued From page 9 a Urinary Tract Infection (UTI) due to his catheter use. Record review indicated Resident #65 was currently being treated with an antibiotic for a UTI. During an observation on 04/02/18 at 10:52 AM, Resident #65 was sitting in a recliner beside his bed with his legs elevated. Resident #65 was observed to have a urinary catheter in a privacy bag lying on the floor beside his recliner. During an interview on 04/02/18 at 11:26 AM, Resident #65 was observed sitting in a recliner beside his bed with his legs elevated. Resident #65 was observed to have a urinary catheter in a privacy bag lying on the floor beside his recliner. Resident #65 stated he has sometimes moved himself from his wheelchair to his recliner but he does not move his catheter bag from the wheelchair because "I don ' t want to mess anything up." Resident #65 also stated he never moved or repositioned his catheter bag. During an observation on 04/04/18 at 2:06 PM, Resident #65 was observed sitting in a recliner beside his bed with his legs elevated. Resident #65 was observed to have a urinary catheter in a privacy bag lying on the floor beside his recliner. During an observation on 04/05/18 at 7:52 AM, Resident #65 was observed sitting in his wheelchair with his urinary catheter in a privacy bag attached to his wheelchair. Resident #65 was observed to have urinary catheter tubing lying on the floor beneath his wheelchair. During an observation on 04/05/18 at 8:55 AM with the Staff Development Coordinator (SDC),	F 690	sure resident is not lying on the catheter and tubing is free of kinks. Make sure tubing and drainage bags are off the floor. Catheter should be loosely taped to the resident's inner thigh to keep from pulling or tugging and catheter strap may be used with frail skin. Empty collection bag each shift or as needed and change catheters as ordered by physician and observe for signs/symptoms of infection. All indwelling catheter bags should be in a privacy bag and placed in a catheter bag holder. 2. All other residents with indwelling catheters have the potential to be affected. All other residents with indwelling catheters were audited on 4/5/18 and no tubing or bags were found to be touching the floor. 3. All nursing staff were re-educated on indwelling catheter standards beginning on 4/5/18. 100% of the nursing staff will be educated by 4/27/18. PRN staff not educated by this date will not be allowed to work until they receive the education. 4.An audit tool was developed to monitor indwelling catheter standards. The tool includes medically indicated; bag below bladder; unobstructed flow; tubing and bag off the floor; tubing secured to the leg and individual emptying the container. Audit tools are used on compliance rounds by the Director of Nursing and/or her designee 5 days per week for 4 weeks beginning on 4/9/18 then 3 times weekly times 4 weeks then once weekly times one month for compliance. 5. All findings will be reported to the Quality Assurance Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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	Continued From page 10 Resident #65 was sitting in his recliner with his urinary catheter in a privacy bag sitting on the floor. The SDC stated her expectation was staff to keep all catheter bags and tubing off the floor due to infection control concerns. During an interview on 04/05/18 at 9:06 AM with Nurse Assistant (NA #1), she stated Resident #65 had returned from therapy and wanted to transfer from his wheelchair to his recliner this morning. NA #1 stated she assisted him to move and had attached his catheter bag to the pocket on the side of the recliner, but it usually touched the floor. NA #1 stated they kept the urinary catheter in a privacy bag and she did not let the catheter tubing touch the floor, but the catheter bag did sometimes touch the floor. During an interview on 04/06/18 at 3:12 PM the Director of Nursing stated her expectations were for staff to maintain urinary catheters and tubing off the floor at all times.	F 690	Improvement Committee by the Director of Nursing and/or her designee for compliance times 3 months and then re-evaluate for on-going compliance thereafter.	
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to thoroughly cook unpasteurized eggs until the yolks were firm before serving for 1 of 1 resident reviewed for dietary needs (Resident #25).	F 800	1. Resident #25 was served Eggland's Best unpasteurized eggs on 4/4/18 by frying the eggs per resident request. The facility was honoring the resident's request by purchasing this specific brand	4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 800	Continued From page 11 Resident #25 was admitted to the facility 03/01/16 with diagnoses of cerebrovascular accident and anxiety disorder. A review of the most recent quarterly Minimum Data Set (MDS) dated 01/21/18 indicated Resident #25 was cognitively intact and needed extensive assistance with bed mobility, transfers, toileting, and supervision with setup for eating. Review of the Registered Dietician (RD) note dated 02/21/18 revealed food preferences included 3 fried eggs be served at breakfast. The RD indicated the resident might only eat breakfast and no other meals and identified significant weight loss. A review of the diet card for Resident #25 revealed a regular diet with chopped meats. The diet card also revealed a special request for 3 fried eggs for breakfast. During an observation on 04/02/18 at 8:45 AM, the facility kitchen walk-in refrigerator revealed a carton of 18 unpasteurized eggs and a second carton of 10 unpasteurized eggs. During an interview on 04/02/18 at 8:45 AM, the Dietary Manager (DM) explained Resident #25 requested the specific brand of eggs and wanted them cooked with a liquid yolk. During an observation on 04/04/18 at 8:23 AM, Resident #25 was served 4 undercooked eggs with a liquid yolk. During an interview on 04/04/18 at 9:07 AM, the Dietary Aide (DA) explained she used the	F 800	of egg. He did not want to consume any other brand of eggs. The unpasteurized eggs were removed from the facility on 4/4/18. 2. All other residents have the potential to be affected. The Director of Food Services performed an additional audit on 4/4/18 to ensure only pasteurized eggs were available in the kitchen. It was determined that no other residents received unpasteurized eggs at any meal or snack. 3. On 4/4/18, the Registered Dietitian and Director of Food Services provided education to 100% of the facility's dietary staff via face to face or phone call trainings. The education topic was "Ensuring resident safety when serving eggs' which clarified for staff that no unpasteurized eggs will be served to any residents. The facility will only purchase pasteurized eggs for resident consumption. 4. An audit tool was created to monitor compliance with only pasteurized egg purchases by the facility. The Director of Food Services and/or her designee will monitor daily for 1 month and then weekly for 2 months to ensure compliance. 5. All findings will be reported to the Quality Assurance Performance Improvement Committee by the Director of Food Services for compliance times 3 months and then re-evaluate for on-going compliance thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 800	Continued From page 12 unpasteurized eggs to cook breakfast for Resident #25. The DA revealed she was instructed by the Dietary Manager to cook the eggs with an undercooked liquid yolk. During an interview on 04/04/18 at 10:22 AM, the DM explained Resident #25 wasn't eating breakfast and told her he didn't like the eggs they were serving. She explained the resident wanted a bigger egg and specifically asked for a brand of eggs. She added the staff had been preparing the unpasteurized eggs with liquid yolks for the past 6 months. The DM revealed she had not educated the resident about the risk of salmonella bacteria when eating unpasteurized eggs. An interview was conducted with Quality Assurance (QA) personnel of the specific eggs purchased for Resident #25 on 04/04/18 at 10:47 AM. The QA personnel explained the pasteurization process changed the egg texture but not the taste. The QA personnel recommended to cook the eggs until the yolks and whites were firm. During an observation on 04/04/18 at 11:08 AM, the safe handling instructions on the carton of unpasteurized eggs used to prepare breakfast for Resident #25 read in part: to prevent illness from bacteria cook eggs until yolks are firm. During an interview on 04/06/18 at 12:32 PM, the Administrator revealed his expectations of serving unpasteurized eggs were for them to be thoroughly cooked on both sides until firm.	F 800		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 812	Continued From page 13 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label egg cartons designated for a resident, properly store a leftover portion of ham, properly date opened cheese, and discard expired food for 1 of 1 walk-in refrigerators. The facility also failed to date nutritional supplement shakes, and discard expired food for 2 of 2 refrigerators designated for resident use. During an observation on 04/02/18 at 8:45 AM, tour of the facility kitchen walk-in refrigerator revealed: 1. A carton of 18 unpasteurized eggs and a carton of 10 unpasteurized eggs with no name. 2. 2 unopened cooked hams and 1 leftover portion of a cooked ham being stored in the same plastic container. The leftover ham was not	F 812	1. There were food labeling and dating errors on food items in the walk-in cooler and nutrition room refrigerators. A carton of Eggland's Best unpasteurized eggs was not designated for a specific resident who had requested them. A portion of a ham was properly dated but not securely covered. A plastic bag containing four blocks of cheese was missing an opened on date. A plastic bag containing 4 waffles had expired. There were labeling and dating errors on supplements including 4 house shakes. All items that did not have proper dating and/or covering were removed and discarded on 4/2/18 by the Director of Food Services. 2. All other residents have the potential of being affected by the deficient practice. All	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 812	Continued From page 14 completely wrapped, exposing the meat. 3. A zip-lock plastic bag containing 4 blocks of sliced yellow cheese, each approximately 2 inches thick labeled 04/01/18, but had no expiration date or use-by-date. 4. A plastic bag containing 4 ready to serve waffles labeled use by 03/29/18. During an interview on 04/02/18 at 8:45 AM, the Dietary Manager (DM) explained the 2 cartons of eggs were purchased for 1 resident who specifically requested that brand of eggs. The DM also explained food should be clearly labeled and dated with an open/used by date and expired food should be discarded. The DM also explained the leftover portion of the ham should be securely wrapped to completely cover the meat. During an interview on 04/04/18 at 10:22 AM, the DM confirmed the resident ' s name was not on the 2 cartons of unpasteurized eggs. The DM explained the staff knew not to serve those eggs to anyone else and to only use them when preparing the individual resident ' s breakfast meal. During an observation on 04/02/18 at 9:01 AM, a refrigerator designated for residents revealed 4 individual supplement shakes with no dates of when it was removed from the freezer. During an observation on 04/02/18 at 9:13 AM, a second refrigerator designated for residents revealed one large open container of supplement shake used for multiple residents with no open date. The refrigerator also contained approximately 4 small bowls of applesauce wrapped in plastic with no date.	F 812	refrigerated food items were checked to ensure they were properly dated and covered on 4/2/18. No items not properly dated or stored were served to other residents. 3. On 4/4/18, the Registered Dietitian and Director of Food Services provided education to 100% of the facility's dietary employees via face to face and phone call training. The staff were educated on proper food labeling, dating of food, drink and supplement items in refrigerators throughout the facility. The Staff Development Coordinator educated all licensed nurses on proper dating of food, drink and supplement items by 4/27/18. A new labeling method was implemented on 4/10/18 using pre-made stickers daily to label all items that need to be discarded in three days. Dietary staff were educated on monitoring the labeling and dating of every refrigeration unit twice daily. Dietary staff were also educated on the importance of securely covering and properly storing all food items in the dry storage area, refrigeration and freezer units. 4. The Registered Dietitian and Director of Food Services created three monitoring tools titled, "Audit of food service purchases", "Walk-in refrigerator and main dining room refrigerator tracking log" and "Nutrition room and activity room refrigerator tracking log". The implementation of these monitoring tools will ensure all food, drink and supplement items are properly labeled, dated and handled. The refrigeration units will be monitored twice daily for one month, once	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(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 812	Continued From page 15 During an interview on 04/02/18 at 9:13 AM, the DM explained dietary is responsible for stocking and checking for expired foods in refrigerators designated for residents. During an interview on 04/04/18 9:11 AM, the DM explained supplement shakes were taken directly from the freezer and should be dated when removed and used within 5 days. During an interview on 04/06/18 at 12:32 PM, the Administrator revealed his expectations were for food to be properly stored and labeled and staff to follow serve safe guidelines. He also revealed the DM was serve safe certified.	F 812	daily for one month and then weekly for one month to ensure compliance. The Director of Food Services will be responsible for ensuring all food, drink and supplement items are properly labeled and dated in the facility's refrigeration units. 5. All findings will be reported to the Quality Assurance Performance Improvement Committee by the Director of Food Services and/or her designee to ensure compliance times 3 months and then re-evaluate for on-going compliance thereafter.	