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 _____	10/14/2021

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
E 000	Initial Comments An unannounced Recertification Survey was conducted on 10/11/21 through 10/14/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 33FD11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted 10/11/21 through 10/14/21. Event ID# 33FD11.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		11/7/21

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

Electronically Signed | 11/04/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the base of a toilet in sanitary condition for 1 of 15 rooms (Room #302), maintain a bedside commode in good condition for 1 of 3 bedside commodes (Room #302), maintain doors in good condition for 2 of 15 rooms (Room #309 and Room #310), and maintain wheelchair brakes in sanitary condition for 1 of 13 wheelchairs (Wheelchair #1) reviewed for a safe, clean, comfortable, and homelike environment. Findings included: 1. An observation of the bathroom of Room #302 on 10/11/21 at 10:21 PM revealed a black substance that was easily removable at the base of the toilet and the front metal bar of a beside commode that was sitting over the toilet had an area of rust to the front bar. Observations of the bathroom of Room #302 on 10/13/21 at 2:20 PM and on 10/14/21 at 8:11 AM revealed the base of	F 584	F584 Maintaining a toilet and wheelchair in sanitary condition and maintaining a bedside commode and resident doors in good condition were areas of concern. Corrective action: On 10/14/21 the Maintenance Director completed the following corrective actions: The base of the toilet was cleaned. Additionally, the toilet and wax ring were replaced. The bedside commode was removed and replaced. The resident doors were repaired and free from damage and the wheelchair break was cleaned. Systematic Changes: Each Department Manager was provided education by the Administrator and/or Staff Development Coordinator beginning 10/15/21 and completed on 10/18/21 on	

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F 584	Continued From page 2 the toilet and the rust to the bedside commode remained unchanged. A joint interview with the Administrator and Maintenance Director on 10/14/21 at 2:08 PM revealed administrative staff rounded on the rooms daily and should have seen and reported the black substance at the base of the toilet and rust on the bedside commode. They explained work order requests could be put into a computerized system to alert maintenance of concerns or staff could document concerns on the daily room rounding sheet. The Maintenance Director stated the black substance to the base of the toilet was due to a leaking wax ring and would be repaired immediately. He stated housekeeping staff should have seen and reported the rust to the bedside commode when they cleaned bathrooms daily. Both the Administrator and Maintenance Director stated missing the concerns with the toilet and bedside commode were oversights by staff. 2. (a). An observation of the bathroom door of Room #309 on 10/11/21 at 03:12 PM revealed a linear scrape with rough edges. Observations of the bathroom door of Room #309 on 10/13/21 at 2:06 PM and on 10/14/21 at8:28 AM revealed the door remained unchanged. (b). An observation of the bathroom door of room #310 on 10/11/21 at 03:19 PM revealed 2 linear scrapes mid-way up the door with rough edges. Observations of Room #310's bathroom door on 03/12/21 at 09:39 AM, 10/13/21 at 1:54 PM, and 10/14/21 at 8:33 AM revealed the door remained unchanged. A joint interview with the Administrator and	F 584	the facility room round procedure and expectations for maintaining a safe, clean, comfortable, and homelike environment. The Housekeeping Department was provided education by the Administrator and/or Staff Development Coordinator beginning 10/15/21 and completed on 10/18/21 on facility cleaning procedures and expectations. The Maintenance Director and Certified Nursing Assistants were provided education by the Administrator and/or Director of Nursing beginning 10/15/21 and completed on 10/25/21 on wheelchair cleaning schedule and sanitation. All facility staff will be re-educated on the procedure for creating work orders to be addressed by the facility Maintenance Director no later than 11/7/21. To correct the alleged areas of concern room round forms will be amended to include door and bedside commode condition and wheelchair and toilet cleanliness. Daily manager room rounds (M-F) will address individual issues and be input into the TELS electronic maintenance system for work orders. Beginning 11/1/21 all repairs will be addressed and completed by 11/07/21. All newly hired employees will be educated as part of the orientation process regarding maintaining a homelike environment. The education will review maintenance cleaning and submission of	

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F 584	Continued From page 3 Maintenance Director on 10/14/21 at 2:08 PM revealed administrative staff rounded on the rooms daily and should have seen and reported the scrapes to the bathroom doors. They explained work order requests could be put into a computerized system to alert maintenance of concerns or staff could document concerns on the daily room rounding sheet. Both the Administrator and Maintenance Director stated missing the concerns with the bathroom doors was an oversight by staff. 3. An observation of the brakes of Wheelchair #1 on 10/11/21 at 03:18 PM revealed dried debris to both brakes. Observations of the brakes of Wheelchair #1 on 10/12/21 at 9:40 AM, on 10/13/21 at 1:55 PM, and on 10/14/21 at 8:34 AM revealed the debris on the brakes remained unchanged. A joint interview with the Administrator and Maintenance Director on 10/14/21 at 2:08 PM revealed administrative staff rounded on the rooms daily and should have seen and reported the dried debris to the brakes of Wheelchair #1. They explained work order requests could be put into a computerized system to alert maintenance of concerns or staff could document concerns on the daily room rounding sheet. A follow-up interview with the Administrator on 10/14/21 at 2:58 PM revealed all wheelchairs were pressure washed by maintenance monthly and they were last deep cleaned a month ago. She also stated wheelchairs were wiped down weekly and as needed by housekeeping and Wheelchair #1's brakes having dried debris on them was an oversight by staff.	F 584	work orders. Monitoring: The Administrator or designee will audit 15 rooms throughout the facility each week for four weeks, then 10 rooms each week for four weeks, then 5 rooms each week for four weeks, for bedside commode condition, door conditions, and toilet cleanliness. The Administrator will review audit weekly. The Administrator or designee will audit 20 wheelchairs throughout the facility each week for four weeks, then 15 wheelchairs each week for four weeks, then 10 wheelchairs each week for four weeks for cleanliness. The Administrator will review audit weekly. POC completion date 11/7/21. The Administrator is responsible for implementing this Plan of Correction and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The audits will be reviewed monthly by the QAPI Committee and recommendations for changes to the plan of correction will occur if the facility is not maintaining compliance with regulatory requirements. The plan of correction can be changed to include additional education and monitoring to obtain and maintain substantial compliance.	

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F 810	Continued From page 4	F 810		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to provide adaptive equipment for 2 of 5 residents (Resident #14 and Resident #81) reviewed for nutrition. Findings included: 1. Resident #14 was admitted to the facility 03/06/18 with diagnoses including paralysis of all four limbs and anxiety. A Physician's order dated 06/25/21 revealed Resident #14 was to receive a low concentrated sugar diet with built up utensils (utensils with larger handles) and a scoop plate (a plate with a lip that enables food to be placed on utensils more easily) for meals. The quarterly Minimum Data Set (MDS) dated 07/15/21 revealed Resident #14 was cognitively intact and required extensive assistance with eating. Resident #14's nutrition care plan last updated 09/28/21 revealed she desired weight loss and was on a therapeutic diet. The goal was to not have weight gain through the next review.	F 810	F810 Facility□s failure to provide adaptive equipment for residents who require assistive devices when consuming meals and snacks were areas of concern. Corrective action: On 10/12/21 the Director of Nursing provided the CNA with education regarding meal tray pass and how to address inaccuracies should they occur. On 10/12/21 Dietary Manager provided the Dietary Aide with education on meal ticket tickets and tray line procedures for checking accuracy and completeness. On 10/12/21 the Director or Nursing and Regional Clinical Coordinator audited all diets, to include adaptive equipment, in the electronic medical record system (Matrix) to ensure the dietary Tray Card system had corresponding information. No inaccuracies were identified. Additionally, significant weight losses were reviewed to ensure there was no weight loss due to inconsistencies in providing adaptive devices. No significant weight	11/7/21

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F 810	Continued From page 5 Interventions included providing adaptive feeding equipment as ordered/needed/recommended, administering medications as ordered, providing diet as ordered, encouraging her to eat slowly, and monitoring her weight. An observation of Resident #14 on 10/11/21 at 12:30 PM revealed she was eating her lunch meal on a regular plate. Review of Resident #14's meal tray ticket at the same date and time revealed she was to receive her food on a scoop plate. An interview with Resident #14 on 10/11/21 at 12:31 PM revealed she was supposed to receive her meals on a scoop plate but for the past couple of days she had received her food on a regular plate. Resident #14 stated a scoop plate was easier for her to use when feeding herself and she preferred to receive her food on a scoop plate. An interview with Nurse Aide (NA) #1 on 10/11/21 at 12:34 PM revealed she served Resident #14 her meal tray for lunch on 10/11/21 and saw that her meal tray ticket stated she was to receive her food on a scoop plate. NA #1 stated she was not sure why Resident #14 did not receive her food on a scoop plate and she was not sure if she should notify the nurse or not. NA #1 confirmed she did not notify the kitchen or Resident #14's nurse that she did not receive her food on a scoop plate. She stated Resident #14's food was served on a regular plate from time to time and she was not sure why she did not always receive her food on a scoop plate. An interview with the Occupational Therapist (OT) on 10/11/21 at 2:08 PM revealed Resident #14	F 810	losses were identified relating to adaptive equipment. On 10/12/21 Occupational therapy also reviewed resident roster for potential need for adaptive equipment. Any residents identified were evaluated. Systematic Changes: All dietary staff were provided education by the Administrator and/or Staff Development Coordinator on 10/12/21 regarding adaptive equipment, meal tickets, and meal tray accuracy. All Nursing staff were provided education by the Administrator and/or Staff Development Coordinator beginning 10/12/21 and ending 11/5/21 regarding tray pass procedures, verifying accuracy of meal tickets, and reporting issues to supervising nurse or dietary staff. All new hire training will include education on tray pass accuracy and adaptive equipment. Monitoring: The Administrator or designee will utilize resident roster identifying individuals requiring adaptive equipment to create an audit tool. Each tray (breakfast, lunch, and dinner) for each resident identified will be audited to ensure adaptive equipment is provided as required. The audit will occur five days a week M-F for four weeks, then three days each week for four weeks, then once a week for four weeks.	

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F 810	Continued From page 6 was supposed to receive her food on a scoop plate because she had a lack of coordination and the scoop plate was helpful for her to place food on her utensils. She explained the scoop plate should be provided with all meals including sandwiches or finger foods. The OT stated if Resident #14 did not receive her meals on a scoop plate NAs should notify Resident #14's nurse. An interview with the Dietary Manager on 10/11/21 at 2:35 PM revealed if residents had orders for adaptive equipment the type of adaptive equipment was listed on the resident's meal tray ticket. He explained the process for plating food was for a Dietary Aide to notify the Cook if any adaptive plates were ordered when the food was plated. The Dietary Manager stated the last Dietary Aide on the tray line was to check the meal tray for accuracy before the meal tray left the kitchen. He stated if a resident meal ticket stated they were to receive adaptive equipment he expected the resident to receive the ordered adaptive equipment. An interview with Dietary Aide #2 on 10/11/21 at 2:39 PM revealed she was the last dietary staff member to check lunch meal trays before they left the kitchen on 10/11/21. She stated she was responsible for checking Resident #14's meal tray for accuracy and it was an oversight that Resident #14 did not receive a scoop plate. An interview with the Administrator on 10/14/21 at 12:59 PM revealed if a resident had orders for adaptive meal equipment, she expected the resident to receive the adaptive equipment. 2. The medical record revealed Resident #81	F 810	POC completion date 11/7/21. The Administrator is responsible for implementing this Plan of Correction and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The audits will be reviewed monthly by the QAPI Committee and recommendations for changes to the plan of correction will occur if the facility is not maintaining compliance with regulatory requirements. The plan of correction can be changed to include additional education and monitoring to obtain and maintain substantial compliance.	

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F 810	Continued From page 7	F 810		

was admitted to the facility 01/08/20 with diagnoses including hemiplegia (paralysis on one side of the body) and stroke.

The quarterly Minimum Data Set (MDS) dated 09/09/21 revealed Resident #81 was severely cognitively impaired and required extensive assistance for eating.

Resident #81's nutrition care plan last updated 09/15/21 revealed she was at risk for aspiration (food or liquids being sucked into the airway). The goal was for Resident #81 to be free from any signs or symptoms of aspiration through the next review. Interventions included providing adaptive feeding equipment as ordered/needed/recommended, providing her diet as ordered, and observing her for coughing, fever, or changes in breathing.

Resident #81's diet order dated 09/17/21 revealed she was to receive a no added salt diet with food cut into bite sized pieces and a scoop dish for all meals.

An observation of Resident #81 on 10/11/21 at 12:35 PM revealed she was feeding herself lunch and her food was served on a regular plate. Observation of Resident #81's meal tray card at the same date and time revealed she was to receive her food on a scoop plate.

An interview with Nurse Aide (NA) #1 on 10/11/21 at 12:34 PM revealed she served Resident #81 her meal tray for lunch on 10/11/21 and saw that her meal tray ticket stated she was to receive her food on a scoop plate. NA #1 stated she was not sure why Resident #81 did not receive her food on a scoop plate and she was not sure if she

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should notify the nurse or not. NA #1 confirmed she did not notify the kitchen or Resident #81's nurse that she did not receive her food on a scoop plate.

An interview with the Occupational Therapist (OT) on 10/11/21 at 2:08 PM revealed Resident #81 was supposed to receive her food on a scoop plate because her stroke affected her right arm which was her dominant hand and left her with visual deficits on her right side. She stated Resident #81 had to feed herself with her left hand and the scoop plate was helpful for her to place food on her utensils or pick up finger foods. The OT confirmed the scoop plate should be provided with all meals including sandwiches or finger foods. The OT stated if Resident #81 did not receive her meals on a scoop plate NAs should notify Resident #81's nurse.

An interview with the Dietary Manager on 10/11/21 at 2:35 PM revealed if residents had orders for adaptive equipment the type of adaptive equipment was listed on the resident's meal tray ticket. He explained the process for plating food was for a Dietary Aide to notify the Cook if any adaptive plates were ordered when the food was plated. The Dietary Manager stated the last Dietary Aide on the tray line was to check the meal tray for accuracy before the meal tray left the kitchen. He stated if a resident meal ticket stated they were to receive adaptive equipment he expected the resident to receive the ordered adaptive equipment.

An interview with Dietary Aide #2 on 10/11/21 at 2:39 PM revealed she was the last dietary staff member to check lunch meal trays before they left the kitchen on 10/11/21. She stated she was

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F 810	Continued From page 9 responsible for checking Resident #81's meal tray for accuracy and it was an oversight that Resident #81 did not receive a scoop plate. An interview with the Administrator on 10/14/21 at 12:59 PM revealed if a resident had orders for adaptive meal equipment, she expected the resident to receive the adaptive equipment.	F 810		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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, record review, and staff interviews, the facility failed to remove expired food stored ready for use in 1 of 1 walk-in refrigerator, and ensure staff had all hair covered during food production which had the potential to cause cross-contamination of food served to	F 812	F812 Facility□'s failure to remove expired food stored in refrigerator and ensure all staff had all hair covered during food production were areas of concern.	11/7/21

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F 812	Continued From page 10 residents in 2 of 6 dietary staff. Findings included: 1. An observation in the walk-in refrigerator on 10/11/2021 at 9:39 AM revealed a sealed plastic bag of sliced onions dated 9/29/2021. The sliced onions showed signs of spoilage that included discoloration, a fluid coating, and foul odor. Signage titled "Refrigeration Date Storage Chart" posted on the outside door of the walk-in refrigerator and observed on 10/11/2021 at 9:39 AM stated, "cut or prepared vegetables should be used or discarded in 7 days". Follow up observation on 10/11/2021 at 2:27 PM revealed the same sealed plastic bag of sliced onions dated 9/29/2021 in the walk-in refrigerator. Interview with the Dietary Manager (DM) on 10/11/2021 at 2:27 PM revealed the onions were expired and should not have been kept in the walk-in refrigerator beyond 7 days. The Administrator stated in an interview on 10/14/21 at 11:53 AM that her expectation was expired foods be thrown away and not used. 2. Observation in the kitchen on 10/13/2021 at 10:37 AM revealed Dietary Aide (DA) # 1 cleaning out a tray cart. DA #1's hair was fashioned in a bun with loose ends of hair hanging down the front and sides of her head. A hair net covered the bun and not the loose ends of hair hanging down the front or sides of her head. A continuous observation on 10/13/2021 from 11:26 AM through 11:35 AM revealed DA #1's hair	F 812	Corrective action: On 10/11/21 the facility dietary manager immediately discarded the onions that were found to be expired. On 10/14/21 the two employees not properly wearing a hair net were educated and corrected the placement of their hair nets. Systematic Changes: All dietary staff were provided education 10/15/21 during mandatory departmental meeting regarding food storage requirements, expiration dating, appropriately discarding expired food. All dietary staff were provided education on or 10/15/21 during mandatory departmental meeting regarding proper use of hair nets. Hair nets must cover the head of hair, may not expose hair on front or back of head, and allow for hair to be tucked into netting. New hire dietary employees will be educated during orientation in the kitchen. This process will be part of the skills check off list for each new hire. Monitoring: The Administrator or designee will audit the dietary department to ensure that expired items are discarded, and all dietary staff are wearing hair nets appropriately. The audits will be conducted daily M-F for 4 weeks, then three times a week for four weeks, then once a week for four weeks. The	

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 _____	10/14/2021

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 812	Continued From page 11 fashioned in a bun with loose ends of hair hanging down the front and sides of her head. A hair net covered the bun and not the loose ends of hair hanging down the front or sides of her head as she unwrapped slices of cheesecake, pureed, then scooped them into individual dessert containers. A continuous observation on 10/13/2021 from 11:43 AM through 12:15 PM revealed DA #1's hair fashioned in a bun with loose ends of hair hanging down the front and sides of her head. A hair net covered the bun and not the loose ends of hair hanging down the front or sides of her head as she assembled resident trays on the service line, and routinely reached into the refrigerator for perishable food items. Interview with DA #1 on 10/13/2021 at 1:41 PM revealed a hair net needed to be on her head to enter the kitchen and she usually wore it covering her full head of hair. DA #1 stated her hair net had a habit of slipping back on her head. Observation on 10/14/2021 at 10:54 AM revealed Cook #1's hair fashioned in a bun with loose ends of hair hanging down the front and sides of her head. A hair net covered the bun and not the loose ends of hair as she covered containers of macaroni and cheese. Interview with Cook #1 on 10/14/2021 at 10:54 AM revealed the hair net was supposed to be covering her head and she stated it may have slipped off. Interview with the DM on 10/13/2021 at 12:21 PM revealed his expectation was that hair nets cover all of the head of hair.	F 812	Administrator will review the audits weekly. POC completion date 11/7/21. The Administrator is responsible for implementing this Plan of Correction and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The audits will be reviewed monthly by the QAPI Committee and recommendations for changes to the plan of correction will occur if the facility is not maintaining compliance with regulatory requirements. The plan of correction can be changed to include additional education and monitoring to obtain and maintain substantial compliance.	

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F 812	Continued From page 12 Interview with the Administrator on 10/14/2021 at 11:53 AM revealed her expectation was that hair be restrained and this included hair being pinned back. The Administrator stated typically a hair net was worn and a hair net was preferred when hair was restrained.	F 812		