STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD 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
E 000	Initial Comments An unannounced Recertification survey was conducted on June 20, 2022 through June 22, 2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID EQM811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 06/20//22 through 06/22/22. There were two allegations investigated and they were not substantiated. Intakes:NC00184034. Event ID# EQM811.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		7/20/22

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

Electronically Signed | 07/13/2022

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F 561	Continued From page 1 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews, the facility failed to allow residents who were assessed to be safe smokers the ability to smoke independently per their individual preference for 2 of 4 residents assessed for preferences (Resident #18 and #19). Findings included: A review of the facility document titled "Smoking Policy" reviewed/revised 4/29/2022. Based upon the interdisciplinary evaluation, a decision will be made whether the guest/resident is a safe or unsafe smoker. A. If the interdisciplinary team determines that the guest/resident is an unsafe smoker, the guest/resident is required to wear a protective smoking vest/apron and is supervised while smoking. The degree of supervision is determined by the team and is based on the smoking evaluation, the physical attributes of the smoking area, and other relevant factors. Important : All Guests/Residents Who Smoke Will Be Supervised. Review of a facility document titled "Supervised Smoking Times" read in part; due to current COVID guidelines all residents are to be supervised while they are smoking. Any resident who is COVID positive is not allowed to smoke. The list contained the following smoking times: 8:45 AM - 9:00 AM, 11:00 AM - 11:15 AM, 1:30	F 561	F561: The facility will allow residents who are assessed to be safe smokers the ability to smoke independently per their individual preference. Resident #18 and Resident #19 had new smoking evaluations completed on 6.29.22 and care plans will be updated by 7.13.22 to reflect current status. Current residents that smoke have the potential to be affected. Current residents that smoke had new smoking evaluations completed on 6.29.22 and care plans updated as indicated by 7.13.22. No negative outcome was identified relating to these evaluations. Residents that smoke will be evaluated by a licensed nurse upon admission, significant change in condition, quarterly and annually thereafter. (Residents will be evaluated using the smoking evaluation tool). Nursing staff will be inserviced by the ADON by 7.18.22 on the facility process for evaluating residents that smoke to determine if they are capable of smoking independently or if they require	

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F 561	Continued From page 2 PM -1:45 PM, 4:00 PM - 4:15 PM, 7:00 PM - 7:15 PM, 9:30 PM - 9:45 PM. A. Resident #18 was admitted to the facility on 3/26/2021. Review of care plan initiated 3/26/2021 revealed he had a care plan for smoking related to covid-19 pandemic with interventions that included supervision with smoking. Review of Resident #18's most recent Minimum Data Set (MDS), an annual assessment, dated 4/2/2022 revealed he was cognitively intact, required supervision for Activities of Daily Living (ADLs) and was coded for tobacco use. Review of Residen t#18's smoking evaluations on 12/1/2021, 12/27/2021, 3/27/2022 indicated Resident #18 was a safe smoker with no supervision required. Smoking evaluation on 3/1/2022 and 6/6/2022 revealed Resident #18 was a safe smoker with supervision. The smoking evaluation for safe smoker included: resident handled ash correctly, was able to light cigarette correctly and put cigarette out safely, had manual dexterity and quick reflexes. Interview was conducted with Resident #18 on 6/20/2022 at 3:35PM, he revealed he was unhappy he was a supervised smoker, he felt it was "unfair, he was 70 years old and did not need supervision." He indicated he was told by Administration that every smoker including Resident #18 would be supervised due to covid-19 pandemic restrictions, whether they were a safe smoker or not. Resident #18 stated that previously he was allowed to smoke whenever he wanted too. He was interviewed	F 561	supervision, as well as the revised smoking policy. A QA monitoring tool will be utilized to ensure ongoing compliance by the Unit Manager and or ADON beginning on 7.20.22. The Unit Manager will audit 2 smoking evaluations weekly x 4 weeks then every other week x 4 weeks then randomly x 4 weeks to ensure that residents who are assessed to be safe smokers have the ability to smoke independently per their individual preference. Variances will be corrected at the time of observation and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 7.27.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random electronic medical record audits and through the facility□s Quality Assurance Program. ADON will provide monitoring tool to the QA Committee. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Completion Date: July 20, 2022	

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F 561	Continued From page 3	F 561		

again on 6/21/2022 at 11:37AM, he stated he had already smoked that morning and was supervised by staff. He revealed there was nothing he could do about being supervised, he just smoked when they told him he could.

B. Resident #19 was admitted to the facility on 12/10/2021.

Review of Resident #19's most recent MDS, an annual assessment, dated 4/4/2022, revealed she was cognitively intact, required supervision with one person assistance for ADLs, and was coded for tobacco use.

Review of care plan with revision date of 6/20/2022 revealed she was care planned for smoking with supervision per facility policy.

Review of Resident #19's smoking evaluation dated 6/20/2022 revealed she was a supervised safe smoker. The evaluation included: resident alert, had consistent decision ability, had manual dexterity, quick reflexes, smoked only in designated areas, safely able to light smoking materials, held smoking materials safely, deposed of ashes in ash tray, and put out cigarette safely.

Interview was conducted with Resident #19 on 6/22/2022 at 9:26 AM. She revealed she was a smoker and had been assessed by the nurse to smoke safely but had to be supervised while smoking due to covid-19 restrictions. She stated she did not know the exact reason for having to be supervised, but she was made to sit at a table by herself while she smoked. Resident #19 stated she was bothered by being unable to go outside and smoke whenever she wanted, but she was a

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F 561	Continued From page 4	F 561		

grown woman and had to follow the rules. She stated she had to be supervised to smoke since covid-19 started.

An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 6/21/2022 at 4:03 PM. They indicated that residents who smoked had been assessed but regardless of the assessment all residents were to be supervised while smoking due to covid precautions. MDS Nurse #2 stated residents who smoked were supervised to ensure they were maintaining a safe distance from one another and were required to sit at separate tables while they smoked. All residents that smoked must go outside to smoke in the designated area and at designated times. They revealed the reason for this was that each resident was in a different stage of covid vaccination or if they had covid previously. Residents had been given choices on smoking times and then they voted on those times. Each resident that smoked was assessed on admission and quarterly thereafter, but it was a company directive that all residents be supervised even if they were assessed as being safe to smoke independently.

An interview was conducted with the Staffing Coordinator on 6/22/2022 at 8:57 AM. She stated her understanding of the smoking policy was that someone had to go outside and supervise all residents while they smoked. She stated Residents #18 and #19 had been assessed to be safe to smoke by themselves, but it was a company policy for all residents to be supervised while they smoked.

The Unit Coordinator was interviewed on 6/22/022 at 9:29 AM: She revealed that newly

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F 561	Continued From page 5	F 561		

admitted residents were made aware on admission what the smoking times were and that all residents were supervised while smoking. She stated because of covid, everyone had to be supervised to keep socially distant from one another.

An interview was conducted with Nurse Aide (NA) #1 on 6/22/2022 at 9:54 AM. She stated she would take residents out to smoke occasionally and supervised them to make sure they weren't sharing tobacco products, were staying a safe distance from one another, and to ensure they returned their smoking materials when they were finished smoking. She revealed it was her understanding all residents that smoked had to be supervised, even the safe smokers. She stated she did not know why they were supervised and had heard residents complain about the smoking times and that they had to be supervised to smoke.

The Assistant Director of Nursing (ADON) was interviewed on 6/22/2022 at 11:44 AM. She revealed supervised smoking was a company policy so that residents that smoke could do so safely outside and maintain social distancing. ADON stated some residents had complained about the smoking times and being supervised to smoke. She indicated Resident #18 complained a lot, he was "very dissatisfied about the supervision and smoking times." She stated Resident #19 complained about being supervised while she smoked and felt like she was an adult and did not need supervision to smoke.

The Director of Nursing was interviewed on 6/22/2022 at 12:03 PM. DON revealed before covid safe smokers did not have to be

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F 561	Continued From page 6	F 561		

supervised, but now all smokers must be supervised while they smoked. She indicated the reason for supervision was the facility needed to maintain each smoker's safety and for infection control. The facility needed to make sure that residents were not sharing cigarettes, maintaining social distance, and putting cigarettes out safely. DON stated Resident #18, and Resident #19 had complained about smoking supervision and smoking times.

An interview was conducted with the Administrator on 6/22/2022 at 12:54 PM: He stated the facility had several residents that went outside to smoke. Administrator revealed all residents that smoke had to be supervised, and it was a company policy due to covid. He stated he had received complaints regarding smoking times, he had discussed the issue with the residents and explained it was a safety issue. He stated, "If it was up to Resident #18 or Resident #19, they would be out there smoking all hours of the day and night."

The Regional Clinical Coordinator was interviewed on 6/22/2022 at 12:57 PM. She revealed a couple of residents in the facility had expressed concerns about the smoking times and supervision while smoking. She stated she had met with the residents a couple of months ago and explained why every resident that smoked had to be supervised, this was to help prevent accidents, such as falling, and to help maintain infection control with social distancing. She stated the smoking policy for supervision had been in place for the last year and smoking times were individually based on each building meaning that each facility within the company could choose their designated smoking times.

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F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) within 14 days following admission to hospice care for 1 of 1 resident reviewed for hospice (Resident #30). The findings included: Resident #30 was readmitted to the facility on 12/14/21 with diagnoses that included dementia. Review of a facility hospice care agreement indicated Resident #30, and her family elected hospice services to start on 12/30/21. Review of Resident #30's SCSA dated 01/19/22 did not indicate she had received hospice care. MDS Nurse #1 and MDS Nurse #2 were interviewed on 06/21/22 at 3:52 PM. MDS Nurse #1 stated they had 14 days after hospice election	F 637	F637: The facility will continue to complete a Significant Change in Status Assessment MDS within 14 days following admission to hospice care. Resident #30□s Significant Change in Status assessment MDS with ARD dated 1.19.22 was modified on 6.21.22 to reflect Hospice status. No negative outcome was identified relating to this assessment. Current residents that have been admitted to Hospice have the potential to be affected. All current residents that have been admitted to Hospice were audited by the MDS Coordinator on 6.29.22 to ensure that Significant Change in Status assessment MDS□s were completed within 14 days. No negative outcomes were identified relating to this audit.	7/20/22

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F 637	Continued From page 8 to complete a SCSA. MDS Nurse #2 explained that generally they found out during morning meetings about residents who had elected hospice care. She further explained that no one had said anything to them about Resident #30 electing hospice services. MDS Nurse #1 stated in a later morning meeting they discovered Resident #30 had elected hospice services and immediately scheduled the SCSA, but it was already passed 14 days. The Director of Nursing (DON) was interviewed on 06/22/22 at 12:32 PM. The DON stated there had been a delay and oversight in getting the hospice information to the MDS Nurses to ensure the SCSA was completed timely. The Administrator was interviewed on 06/22/22 at 1:52 PM. The Administrator stated the SCSA assessment for Resident #30 should have been completed timely.	F 637	The MDS Coordinator was inserviced by the Clinical Resource Specialist on 7.11.22 on completing Significant Change in Status assessment MDS□s within 14 days following admission to Hospice care. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON beginning on 6.29.22. The DON will randomly audit 3 MDS□s weekly x 4 weeks, then every other week x 4 weeks, then randomly x 4 weeks to ensure that Significant Change in Status assessment MDS□s are completed within 14 days of admission to Hospice. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 7.27.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits of MDS assessments and through the facility□s Quality Assurance Program. DON will provide monitoring tool to the QA Committee. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Completion Date: July 20, 2022	

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F 641	Continued From page 9	F 641		
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 interview the facility failed to accurately code the Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) in the area of hospice for 1 of 1 residents reviewed for hospice (Resident #30). The findings included: Resident #30 was readmitted to the facility on 12/14/21 with diagnoses that included dementia. Review of a facility hospice care agreement indicated that Resident #30 and her family elected hospice services to start on 12/30/21. Review of a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) dated 01/19/22 did not indicate that Resident #30 had a prognosis of 6 months or less to live and hospice was not checked on the assessment. Review of a Care Area Assessment worksheet dated 01/23/22 read in part, Resident #30 "and her family have elected hospice services." Review of a care plan updated on 01/18/22 read in part; Resident #30 is receiving hospice services with goal that included hospice care provider and then included their contact information. MDS Nurse #2 was interviewed on 06/21/22 at	F 641	F641: The facility will continue to code assessments to accurately reflect the resident□s status. Resident #30 had an MDS correction completed at the time of discovery on 6.21.22. No negative outcome was identified relating to this observation. Residents that receive Hospice services have the potential to be affected. All current residents that receive Hospice services were reviewed on 6.29.22 to ensure that assessments had been completed that accurately reflect each resident□s status. No negative observations were identified. The MDS Coordinator was inserviced by the Clinical Resource Specialist on 7.11.22 on completing assessments that accurately reflect the resident□s Hospice status. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON beginning on 6.29.22. The DON will randomly audit residents that receive Hospice services monthly x 3 months to ensure that MDS assessments are being	7/20/22

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F 641	Continued From page 10 3:52 PM and confirmed she had completed the SCSA dated 01/19/22. MDS Nurse #2 stated that there was a delay in getting Resident #30's hospice forms signed by her family. Once they were signed there was a delay in getting us that information and when the MDS was being completed it was just an oversight for not checking the appropriate sections that indicated Resident #30 was hospice and had a prognosis of less then 6 months to live. The Director of Nursing (DON) was interviewed on 06/22/22 at 12:32 PM. The DON stated there had been a delay and oversight in getting the hospice information to the MDS Nurses but once they had the information, she would expect the MDS to be completed accurately and reflect the hospice care. The Administrator was interviewed on 06/22/22 at 1:52 PM. The Administrator stated the SCSA assessment for Resident #30 should have been completed as accurately as possible.	F 641	completed that accurately reflect the resident□s Hospice status. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator monthly for the next 3 months beginning on 6.29.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits of MDS assessments and through the facility□s Quality Assurance Program. DON will provide monitoring tool to the QA Committee. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Completion Date: July 20, 2022	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		7/20/22

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F 688	Continued From page 11 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family, and staff interview the facility failed to apply a left-hand splint as ordered to prevent further contractures for 1 of 2 residents reviewed for limited range of motion (Resident #45). The finding included: Resident #45 was admitted to the facility on 05/01/19 with diagnoses that included contracture of muscle of left hand. Review of a physician order dated 07/01/20 read; splint to left hand on in the morning and off at bedtime as tolerated by guest. Review of an Occupational Therapy (OT) discharge summary dated 03/06/21 read in part; patient discharge from OT services with restorative/nursing to manage splinting program. Review of the annual Minimum Data Set (MDS) dated 05/06/22 indicated that Resident #45's cognition moderately impaired and required extensive assistance with activities of daily living. An impairment of range of motion was noted to one upper and lower extremity. Review of a Care Area Assessment dated	F 688	F688: The facility will continue to ensure that splints are applied as ordered to prevent further contractures. Resident #45 continues to wear the left hand splint as ordered. No negative outcome was identified relating to the observation. Current residents with orders for splints have the potential to be affected. Current residents with orders for splints were reviewed on 6.23.22 to ensure that splints are being worn as ordered. No negative outcomes were identified relating to these observations. All nursing staff will be inserviced by the ADON by 7.18.22 on the facility expectation that residents must have splints applied as ordered to prevent further contractures. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON beginning on 6.24.22. The DON will randomly observe 3 guests weekly x 4 weeks then every other week x 4 weeks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 688	Continued From page 12 05/19/22 read in part; Resident #45 has a left-hand splint as tolerated for contracture. Review of an Activities of Daily Living (ADL) care plan updated on 05/20/22 contained an intervention that read: Left resting hand splint as ordered. Review of the June 2022 Treatment Administration Record (TAR) revealed the following: splint to left hand. On in the morning and off at bedtime as tolerated by guest. Check every shift for skin integrity. The order was initialed each day by staff including 06/20/22, 06/21/22, and 06/22/22. An observation of Resident #45 was made on 06/20/22 at 12:07 PM. Resident #45 was up in her wheelchair. Her left hand was observed to be in a fist position and no splint was in place. An interview with Resident #45's family member was conducted on 06/20/22 at 2:09 PM. The family member indicated she visited Resident #45 a couple of times a month and the last couple of times she had visited Resident #45 did not have her hand splint in place. The family member stated that she had seen one on Resident #45 in the past but not recently when she visited. An observation of Resident #45 was made on 06/20/22 at 2:54 PM. Resident #45 was resting in bed with her eyes closed. Her left hand remained in a fist position and no splint was in place. An observation of Resident #45 was made on 06/21/22 at 8:49 AM. Resident #45 was up in her wheelchair in the dining room being assisted with the breakfast meal. Her left hand was in the fist	F 688	then randomly x 4 weeks to ensure that splints are being worn as ordered. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 6.24.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. DON will provide monitoring tool to the QA Committee. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Completion Date: July 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 688	Continued From page 13	F 688		

position with no splint in place.

An observation of Resident #45 was made on 06/21/22 at 12:45 PM. Resident #45 was up in wheelchair being pushed down the hallway towards her room. Her left hand remained in a fist position with no splint in place.

An observation of Resident #45 was made on 06/22/22 at 9:35 AM. Resident #45 was up in her wheelchair at bedside. Her left hand remained in a fist position with no splint in place.

Nurse Aide (NA) #6 was interviewed on 06/22/22 at 11:47 AM. NA #6 confirmed that she had cared for Resident #45 on Monday 06/20/22 and Wednesday 06/22/22 and was familiar with Resident #45's care needs. NA #6 stated that Resident #45 did have a hand splint in the past, but it had been 2-3 weeks since she had seen the splint or applied it because she could not find the left-hand splint. NA #6 again confirmed that she had not applied Resident #45's left hand splint on 06/20/22 or 06/22/22 because she could not find the splint to apply, and she had not told anyone because thought eventually It would turn up. NA #6 did say that when she could find the splint, she would apply it to Resident #45's left hand and she would wear it without difficulty.

The Director of Rehab was interviewed on 06/22/22 at 12:02 PM who stated that Resident #45 had a stroke with left sided hemiparesis and had a left-hand splint. The Director of Rehab stated that the last time Resident #45 was on their caseload was in March 2021 and was discharged either to restorative or as a nursing program (nursing staff would apply the splint) for application of her left-hand splint with finger

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F 688	Continued From page 14	F 688		

separators. She stated she had seen Resident #45 last month (just in passing) and she did not have her splint in place but added when Resident #45 did have her left-hand splint she wore it consistently enough "to do what it needed to do" to prevent further contracture. The Director of Rehab stated she would put Resident #45 on the list to be seen again since her last rehab screen was March of 2021. The Director of Rehab added if the splint was missing, someone should have let therapy know so we could have done "search and seizure" and located the splint or ordered her another one.

Nurse #7 was interviewed on 06/22/22 at 12:16 PM. Nurse #7 confirmed that she worked with Resident #45 on 06/21/22 and 06/22/22 and both days when she checked her she did not have her left-hand splint in place. Nurse #7 stated she had just found out (06/22/22) that Resident #45's left hand splint was missing and had not reported it to therapy yet. Nurse #7 could not recall the last time she had seen Resident #45 wearing the hand splint and added that currently the facility did not have a restorative program so the NAs on the hall were responsible for applying splints as ordered.

The Director of Nursing (DON) was interviewed on 06/22/22 at 12:20 PM. The DON stated that when the facility had a restorative aide applying splints was one of her duties but since the facility did not have the staff for a restorative aide at the present time the NAs on the unit were responsible for applying splints as ordered. The DON could not recall the last time she saw Resident #45 with her left-hand splint in place but added NA #6 was her regular NA and should be applying the splint as ordered. If the splint could

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	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

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F 688	Continued From page 15 not be located, then the Nurse and/or therapy should have been made aware. The Administrator was interviewed on 06/22/22 at 1:50 PM. The Administrator stated that Resident #45's left hand splint should have been applied as ordered.	F 688		
F 838 SS=E	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations	F 838		7/20/22

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	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

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F 838	Continued From page 16 that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to update the facility assessment with the current population of residents that required a life vest (external cardiac defibrillator vest) or the staff training, and competencies required to care for a resident that required a life vest during day-to-day operation or during an	F 838	F838 The facility will review and update the Facility Assessment as necessary to determine what resources are necessary to care for the residents competently during both day to day operations and	

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F 838	Continued From page 17 emergency. This practice had the potential to affect other residents requiring life vests. Findings included: The facility assessment was last updated by the Administrator on 10/19/21. The section, titled, Disease/Conditions, physical and cognitive disabilities of the resident in the facility, indicated the following: Heart/circulatory system: congestive heart failure, coronary artery disease, angina (chest pain), dysrhythmias, hypertension, orthostatic hypotension, peripheral vascular disease, risk for bleeding or clots, deep vein thrombosis, and pulmonary embolism. A section, titled, Resident Support Care Need, included: activities of daily living, mobility/falls, bowel/bladder, skin integrity, mental health behavior, medications, pain management, infection control, management of medical conditions, therapy, nutrition, and other special care needs (dialysis, hospice, ostomy care, tracheostomy care, bariatric care, palliative care, and end of life care). The resident population or support care needed did not mention the use of or care of a life vest. Further review of facility assessment revealed a section titled, Staff Training/Education and included: communication, resident rights, abuse, neglect, infection control, dementia, cognitive impairments, activities of daily living, change in condition, cultural/religious needs, elopement, skin/wound management, culture change, and caring for person with mental and psychosocial disorders. The competencies needed by staff included: activities of daily living, disaster planning, infection control, medication administration, resident assessment, and vital	F 838	emergencies. The Facility Assessment was updated on 7.11.22 to reflect that the facility does care for residents with LifeVests. All other information on the Facility Assessment was reviewed by the Administrator and DON on 7.11.22 and no further changes were noted. No negative outcome was identified relating to this review. The Administrator and DON were inserviced by the Regional Clinical Coordinator on 7.11.22 on the expectation that the Facility Assessment will be reviewed and updated whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. A QA monitoring tool will be utilized by the Regional Clinical Coordinator beginning on 7.20.22. The Regional Clinical Coordinator will randomly audit facility and resident medical records monthly x 3 months to ensure that the Facility Assessment is being reviewed and updated as necessary. Variances will be corrected at the time of observation and additional education provided when indicated. Audit results will be reported to the Administrator monthly for the next 3 months beginning on 7.20.22 and concerns will be reported to the Quality Assurance Committee during monthly	

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	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

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THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

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F 838	Continued From page 18 signs. Specialized competencies included: respiratory care (oxygen/bipap), catheterizations, wound care, dressing, intravenous access, peritoneal dialysis, enteral feeding, parenteral feeding, glucometer, phlebotomy, trach, chest tubes, drains, and caring for post-traumatic stress disorder and trauma. Neither the education nor competencies included the life vest. The Director of Nursing (DON) was interviewed on 06/21/22 at 3:16 PM. The DON confirmed that they currently had one resident that required a life vest but have had several residents in the facility since she had been there over the last two years. When asked if the staff had received any education regarding the life vest and how to manage it on a daily basis or during an emergency, she stated that they left the pamphlet in the resident's room for staff to refer to and verbally instructed the staff that it could be removed during bathing. The DON confirmed that no formal in-service or competency had been completed on the care of the life vest. The DON was unaware that there was washing instructions that needed to be completed with the life vest and was unsure if the staff were or aware or not. The Administrator was interviewed on 06/22/22 at 2:43 PM. The Administrator confirmed that he had updated the facility assessment on 10/19/21 with the information on the residents that were in the facility at that time. He stated he had not made any further changes to the facility assessment since then. The Administrator stated that if the facility admitted someone with a new device like a life vest, he would expect the DON to ensure the staff were trained on the device and ensure the staff were aware of how to care for the resident on day-to-day basis and during an	F 838	meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. RCC will provide monitoring tool to the QA Committee. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Completion Date: July 20, 2022	

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THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

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F 838	Continued From page 19 emergency. The Administrator stated he could certainly go back and add the information on the life vest to keep the facility assessment up to date as possible.	F 838		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		7/20/22

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F 842	Continued From page 20 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to maintain an accurate Treatment Administration Record (TAR) for checking the placement of a left-hand splint for 1 of 2 residents reviewed for limited range of	F 842	F842: The facility will continue to maintain accurate Treatment Administration Records (TAR) for checking placement of splints.	

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	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

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THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

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F 842	Continued From page 21 motion (Resident #45). The findings included: Resident #45 was readmitted to the facility on 05/01/19. Review of a physician order dated 07/01/20 read; splint to left hand on in the morning and off at bedtime as tolerated by guest. Review of the June 2022 Treatment Administration Record (TAR) revealed the following: splint to left hand. On in the morning and off at bedtime as tolerated by guest. Check every shift for skin integrity. The order was initialed each day by staff including 06/20/22, 06/21/22, and 06/22/22. An observation of Resident #45 was made on 06/20/22 at 12:07 PM. Resident #45 was up in her wheelchair. Her left hand was observed to be in a fist position and no splint was in place. An observation of Resident #45 was made on 06/21/22 at 8:49 AM. Resident #45 was up in her wheelchair in the dining room being assisted with the breakfast meal. Her left hand was in the fist position with no splint in place. An observation of Resident #45 was made on 06/22/22 at 9:35 AM. Resident #45 was up in her wheelchair at bedside. Her left hand remained in a fist position with no splint in place. Nurse Aide (NA) #6 was interviewed on 06/22/22 at 11:47 AM. NA #6 confirmed that she had cared for Resident #45 on Monday 06/20/22 and Wednesday 06/22/22. NA #6 stated that Resident	F 842	Resident #45 will continue to have accurate TAR documentation reflecting the use of a left hand splint as ordered. No negative outcome was identified relating to the observation. Current residents with orders for splints have the potential to be affected. TAR□s for current residents with orders for splints were reviewed on 6.23.22 to ensure that splints are being worn as ordered. No negative outcomes were identified relating to these observations. All nursing staff will be inserviced by the ADON by 7.18.22 on the facility expectation that TAR documentation for guests with orders for splints must be accurate. Any staff not inserviced by July 18, 2022 will not be allowed to work until inservice is in compliance. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON beginning on 7.20.22. The DON will randomly audit TAR□s for 3 guests with orders for splints weekly x 4 weeks then every other week x 4 weeks then randomly x 4 weeks to ensure that TAR documentation is accurate. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 7.20.22 and concerns will be reported to the Quality	

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THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

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F 842	Continued From page 22 #45 did have a hand splint in the past, but it had been 2-3 weeks since she had seen the splint or applied it because she could not find the left-hand splint. NA #6 again confirmed that she had not applied Resident #45's left hand splint on 06/20/22 or 06/22/22 because she could not find the splint to apply. Nurse #7 was interviewed on 06/22/22 at 12:16 PM. Nurse #7 confirmed that she worked with Resident #45 on 06/21/22 and 06/22/22 and both days when she checked her she did not have her left-hand splint in place. Nurse #7 confirmed that she had initialed the TAR both days indicating Resident #45's splint was in place and stated that was an error on her part and she would have to go back and unsigned the TAR. The Director of Nursing (DON) was interviewed on 06/22/22 at 12:20 PM. The DON stated that the nursing staff in particular the NAs were responsible for applying the splint and then the Nurse was responsible for ensuring the splint was in place and then documenting that on the TAR. If the splint was not in place the nurse should document that on the TAR to maintain accurate documentation.	F 842	Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. DON will provide monitoring tool to the QA Committee. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Completion Date: July 20, 2022	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		7/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD 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 880	Continued From page 23 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

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F 880	Continued From page 24 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews, the facility failed to follow the Center of Disease Prevention and Control (CDC) recommended guidance for personal protective equipment (PPE) usage for new admission residents who were not fully vaccinated when 3 of 3 staff members (Director of Nursing, NA #2, and Minimum Data Set Nurse #1) were observed entering resident rooms with signage posted that indicated Contact Droplet Precautions without the use of a gown, gloves, or an N-95 respirator mask to deliver meal trays on 1 of 4 halls (400 hall) observed for dining. The findings included: A facility policy titled, "Coronavirus (COVID 19) revised 6/2/22 read under the section titled new admission and readmissions: all guest and residents who are not up to date with all	F 880	F880 The facility will continue to follow the CDC recommended guidance for PPE usage for new admission residents who are not fully vaccinated. Residents #81, #82, and #83 are no longer on transmission-based precautions. Current residents on transmission-based precautions have the potential to be affected. All residents on transmission-based precautions were observed by the ADON/IP with no negative outcome identified as a result of these observations. A root cause analysis was conducted on 7.11.22 by the QAPI committee and plans implemented to	

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	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

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F 880	Continued From page 25 recommended COVID-19 vaccine doses should be placed in quarantine, even if they have a negative test upon admission. The document further indicated under the personal protective equipment section: use PPE including a N-95 mask; a face shieled or goggles, gown, and gloves. It further indicated wear gloves when entering the room when caring for residents and to ensure hands do not come in contact with potentially contaminated surfaces in the environment. According to the CDC recommended guidelines dated 2/22/22 indicated, in general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon admission, and should be tested as described in the testing section above; COVID-19 vaccination should also be offered. Residents who are not up to date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator). a. Resident #81 was admitted to the facility on 06/16/22. A review of Resident #81's immunization revealed he declined the COVID-19 vaccination. A review of Resident #81's hospital labs dated 6/16/22 indicated he was negative for COVID-19, Influenza A&B, and Respiratory Syncytial Virus (RSV).	F 880	achieve systemic change. Transmission based precautions signage has been updated to reflect the most recent version available per SPICE (updated 2.9.22). The DON, NA #2, and MDS nurse #1 were inserviced by the ADON/IP on 6.20.22 on the facility policy (based on CDC guidance) for PPE usage for residents on transmission-based precautions to include new admission residents who are not fully vaccinated. Staff will be inserviced by the ADON/IP by 7.17.22 on the facility policy (based on CDC guidance) for PPE usage for residents on transmission-based precautions to include new admission residents who are not fully vaccinated. Any staff not inserviced by July 17, 2022 will not be allowed to work until inservice is in compliance. Alliant QIO contacted the facility to provide support and education on PPE. Conference call is set up for July 26, 2022 with IDT. A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON/IP/designees beginning on 6.24.22. The ADON/IP/designees will randomly observe 5 staff members entering rooms containing residents on transmission-based precautions everyday x 2 weeks, then 5x/week x 2 weeks, then 3x/week x 4 weeks, then weekly x 4	

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	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

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THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

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F 880	Continued From page 26 A review of Resident #81's physician's orders dated 6/16/22 indicated Contact and Droplet Isolation (Transmission Based Precautions) r/t COVID-19 vaccination status. A review of Resident #81's COVID-19 plan of care dated 6/20/22 indicated he was placed on Contact/Droplet Isolation on 6/20/22. A continuous observation on 06/20/22 beginning at 12:13 PM and ending at 12:18 PM revealed the Director of Nursing (DON) enter Resident #81's lunch meal tray. The DON was wearing a plastic face shield which was pushed up on the top of her head and not covering her face and a surgical mask. The signage hanging outside Resident #81's door indicated Contact/Droplet Precautions and indicated a gown, gloves, eye protection and a mask were required before entering the room and perform hand hygiene before donning and after doffing PPE in the room but did not indicate the need to wear a N-95 mask. There were PPE supply carts in the hallway fully stocked with gowns, gloves, face shields, surgical masks, and N-95 masks. The door was partially opened, and the DON was observed to sit Resident #81's meal tray down on his overbed table and setup his meal tray. She exited the room and used hand sanitizer from the hallway dispenser. An interview on 06/20/22 at 12:18 PM with the DON revealed she had delivered Resident #81's lunch tray. The DON acknowledged the signage posted outside Resident #81's door which indicated Contact/Droplet Isolation with instructions to don a gown, gloves, eye protection, and a face mask. The DON said knew Resident #81 was on transmission-based precautions but had "only been setting up a meal	F 880	weeks to ensure that staff are following the facility policy (based on CDC guidance) for PPE usage. The ADON/IP/designees will also verify that each new admission requiring TBP has appropriate signage posted and this will be reflected on the QA monitoring tool. Variances will be corrected at the time of observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months beginning on 7.20.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility□s Quality Assurance Program. ADON will provide monitoring tool to the QA Committee. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Completion Date: July 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

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THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

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F 880	Continued From page 27	F 880		

his meal tray" and had not provided personal hygiene care and didn't think she needed to apply the PPE according to the signage at the time.

An interview on 06/22/22 at 9:15 AM with the Infection Preventionist/Assistant Director of Nursing (IP/ADON) revealed staff have been trained to don full PPE which included a gown, gloves, a face shield, and a N-95 mask before they enter any room labeled as Contact/Droplet Precautions. The IP/ADON indicated the signage listed should clarify the use of a facemask to include a N-95 mask. She indicated all staff were to wear full PPE when delivering meal trays into rooms labeled Contract/Droplet Precautions.

An interview on 06/22/22 at 1:52 PM with the Administrator revealed he expected staff to follow the CDC's recommended guidelines for new admissions on Contact/Droplet Precautions to include the following PPE: a gown, gloves, a face shield, and a N-95 face mask.

b. Resident #82 was admitted to the facility on 06/11/22.

Resident #82's immunization record indicated he had received 3 doses of the COVID-19 vaccine.

A review of the physician's orders for Resident # 82 dated 06/14/22 indicated Contact and Droplet Isolation (Transmission Based Precautions) r/t COVID-19 Vaccination Status not Up to Date.

A review of Resident #82's COVID-19 plan of care dated 6/20/22 indicated he was placed on Contact/Droplet Isolation on 6/11/22.

A continuous observation on 06/20/22 beginning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

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

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F 880	Continued From page 28	F 880		

at 12:19 PM revealed NA #1 entered Resident #82's room wearing a surgical mask and a face shield. He was not observed to don a gown or gloves before entering the room nor apply a N-95 face mask. The signage hanging outside Resident #82's door indicated Contact/Droplet Precautions and indicated a gown, gloves, eye protection and a mask were required before entering the room and hand hygiene was required before donning and after doffing PPE before exiting the room but did not indicate the need to wear a N-95 mask. There were PPE supply carts in the hallway fully stocked with gowns, gloves, face shields, surgical masks, and N-95 masks. The door was opened, and NA #1 was observed to sit Resident #82's meal tray down on his overbed table and setup his lunch. NA #2 exited the room and performed hand hygiene at the meal service cart using hand sanitizer.

An interview on 06/22/22 at 9:15 AM with the Infection Preventionist/Assistant Director of Nursing (IP/ADON) revealed staff have been trained to don full PPE which included a gown, gloves, a face shield, and a N-95 mask before they enter any room labeled as Contact/Droplet Precautions. The IP/ADON indicated the signage listed should clarify the use of a facemask to include a N-95 mask. She indicated all staff were to wear full PPE when delivering meal trays into rooms labeled Contract/Droplet Precautions.

An interview on 06/22/22 at 1:52 PM with the Administrator revealed he expected staff to follow the CDC's recommended guidelines for new admissions on Contact/Droplet Precautions to include the following PPE: a gown, gloves, a face shield, and a N-95 face mask.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

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

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F 880	Continued From page 29	F 880		

c. Resident #83 was admitted to the facility on 06/14/22.

A review of Resident #83's COVID-19 vaccination card scanned in the electronic medical record he had received 2 doses of the Moderma COVID-19 vaccine with the following dates listed: 01/26/21 and 02/24/21.

A review of Resident #83's hospital lab dated 06/14/22 indicated his COVID antigen test result was negative.

A review of the physician's orders for Resident # 83 dated 06/14/22 indicated Contact and Droplet Isolation (Transmission Based Precautions) r/t COVID-19 Vaccination Status not Up to Date.

A review of Resident #83's COVID-19 plan of care dated 6/15/22 indicated he was placed on Precautionary COVID-19 Isolation on 6/15/22 through 6/23/22.

An observation on 06/20/22 at 12:20 PM revealed Minimum Data Set (MDS) Nurse #1 enter Resident #83's room wearing a surgical mask and a face shield. She was not observed to don a gown or gloves before entering the room nor apply a N-95 face mask. The signage hanging outside Resident #83's door indicated Contact/Droplet Precautions and indicated a gown, gloves, eye protection and a mask were required before entering the room and hand hygiene was required before donning and after doffing PPE before exiting the room but did not indicate the need to wear a N-95 mask. There were PPE supply carts in the hallway fully stocked with gowns, gloves, face shields, surgical masks, and N-95 masks. The door was opened, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING _____ B. WING _____	C 06/22/2022

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

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F 880	Continued From page 30	F 880		

MDS Nurse #1 was observed to sit Resident #83's meal tray down on his overbed table and setup his lunch. MDS Nurse #1 exited the room and performed hand hygiene at the meal service cart using hand sanitizer.

An interview on 06/20/22 at 12:22 PM with MDS Nurse #1 acknowledged Resident #83 was on transmission-based precautions of Contact/Droplet Precautions. MDS Nurse #1 indicated she did not notice the sign when she entered the room without donning full PPE of gown, gloves, face shield, and a N-95 face mask although had been educated on the use of PPE in rooms labeled with Contact/Droplet Precautions.

An interview on 06/22/22 at 9:15 AM with the Infection Preventionist/Assistant Director of Nursing (IP/ADON) revealed staff have been trained to don full PPE which included a gown, gloves, a face shield, and a N-95 mask before they enter any room labeled as Contact/Droplet Precautions. The IP/ADON indicated the signage listed should clarify the use of a facemask to include a N-95 mask. She indicated all staff were to wear full PPE when delivering meal trays into rooms labeled Contract/Droplet Precautions.

An interview on 06/22/22 at 1:52 PM with the Administrator revealed he expected staff to follow the CDC's recommended guidelines for new admissions on Contact/Droplet Precautions to include the following PPE: a gown, gloves, a face shield, and a N-95 face masks.