STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 06/16/2023

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 and complaint investigation survey was conducted on 06/12/23 through 06/16/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # NYIM11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 06/12/23 to conduct a recertification and complaint survey and exited on 06/15/23. Additional information was obtained on 06/16/23. Therefore, the exit date was changed to 06/16/23. Event ID #NYIM11. The following intakes were investigated NC00190525, NC00190787, NC00194472, NC00195496, NC00195845, NC00196265, NC00202394. 6 of the 24 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		7/6/23

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

Electronically Signed | 07/06/2023

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview the facility failed to treat a resident in a dignified manner when Nurse Aide #2 spoke to her in a manner that made her feel "terrible" for 1 of 5 residents (Resident #6) reviewed for dignity. The findings include: Resident #6 was admitted to the facility on 9/25/2018. The quarterly Minimum Data Set dated 5/19/23 revealed Resident #6 was moderately cognitively impaired and had no behaviors or rejection of care.	F 550	F550 Facility failed to treat a resident in a dignified manner. Corrective Action: Nurse Aide #2 will no longer provide care for Resident #6. Nurse Aide #2 was in-serviced on the fundamentals of resident rights, treating residents with dignity and respect on 06-14-2023. Additionally, all alert and oriented residents were interviewed between 6-14-23 to 7-5-23 for any dignity concerns at the facility. For residents who are not able to be interviewed, the responsible	

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F 550	Continued From page 2 During an interview on 6/12/23 at 10:00 AM Resident #6 revealed that Nurse Aide #2 had called her a devil and witch during breakfast. An interview with Nurse Aide #2 on 6/13/23 at 2:16 PM revealed that she had taken Resident #6 her breakfast tray in the morning of 6/12/23 and Resident #6 had stated in a repetitive and increasing louder voice "she's here!". Nurse Aide #2 stated that she had replied with "yeah, the devil is here" and Resident #6 stated "you sure are." Nurse Aide #2 then stated to Resident #6, "Why are you being a grumpy witch?" Nurse Aide #2 indicated that she knew it wasn't appropriate to say that but she's only human and she should have just left the room. A follow up interview with Resident #6 on 6/14/23 at 8:55 AM revealed that the way Nurse Aide #2 spoke to her made her feel terrible but no other staff has spoken to her that way. She stated that she slept well last night and was looking forward to breakfast. An interview with the Director of Nursing and the Administrator on 6/13/23 at 4:42 PM revealed that Nurse Aide #2 informed them about the incident with the Resident #6 on 6/13/23 at 2:30 PM. The Administrator then did a grievance report. They sent Nurse Aide #2 home that afternoon pending further investigation. The Director of Nursing stated her expectation was that everyone be respectful to each other and Nurse Aide #2's response was not appropriate. An interview with the Director of Nursing and the Administrator on 6/14/23 at 10:43 AM revealed that Nurse Aide #2 would no longer work with	F 550	party or family members were interviewed by the Social Worker from 06-14-2023 to 07-05-2023 regarding dignity concerns at the facility. No significant findings noted. Systemic Change: On 06-14-2023 an in-service was initiated for all facility staff and contract staff on the fundamentals of resident rights by the Assistant Director of Nursing; specifically regarding treating residents with dignity and respect. Staff who did not complete the in-service by 07-05-2023 were not allowed to work until the in-service was completed. Treating residents with dignity and respect will be added to all new hire orientation by the Director of Nursing on 7-5-23. Monitoring: Social Services or designee will ask five residents per week if they have been treated with dignity and respect for a month, then five residents bi-weekly for a month, and five residents once a month for one month. The Administrator is responsible for implementing this Plan of Correction (POC) and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee for three consecutive meetings. At which time, the determination will be made if further monitoring is necessary. Recommendations for changes to the POC will occur if the facility does not maintain compliance with regulatory requirements. The POC can be changed	

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F 550	Continued From page 3 Resident #6.	F 550	to include additional education and monitoring to obtain and maintain substantial compliance. The completion date for this plan of correction is 07-06-2023.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with the resident and staff, the facility failed to ensure a dependent resident could access the light switch located behind the bed for 1 of 2 residents reviewed for accommodation of needs. (Resident #139) A. Resident #139 was admitted to the facility on 04/26/23. The admission Minimum Data Set (MDS) dated 05/29/23 assessed Resident #139 with intact cognition. The MDS indicated walking between locations inside or outside the room, and locomotion off unit did not occur for Resident #139 during the assessment periods. Review of Resident #139's medical records revealed she had moved to her current room on 06/09/23.	F 558	F558 Facility failed to ensure a resident could access the light cord located behind the resident's bed. Corrective Action: As soon as the facility was made aware of the concern, the Maintenance Director added an extension string to the light cord for Resident #139. This was completed on 06-13-2023. Systemic Change: The Maintenance Director completed an audit of the entire building's light cords noting no significant findings and that the incident was isolated. This was completed 06-13-2023. Education was also provided to the Maintenance Director and Department Heads from 06-13-2023 through 06-20-2023 by the Administrator	6/21/23

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F 558	Continued From page 4 During an observation conducted on 06/12/23 at 8:37 AM, the switch for the light fixture behind Resident #139's bed was attached with a cord approximately 4 inches in length. The switch was located on the wall approximately 5 feet from the floor and around 4 feet from Resident #139's bed. Resident #139 was unable to reach the cord connected to the switch from the bed if needed. An interview was conducted with Resident #139 on 06/12/23 at 8:38 AM. She stated the access cord to the light switch behind the bed had been in disrepair since she moved to this room on 06/09/23. She indicated that she was bed bound and non-ambulatory. She did not have any control of the lights behind her bed as she could not reach the switch on the wall from her bed. She had to rely on nursing staff to control the light each time and it was very inconvenient to her. During a subsequent observation conducted on 06/13/23 at 2:44 PM, the access cord attached to the light switch behind Resident #139's bed remained in disrepair. During a joint observation was conducted with Nurse Aide (NA) #1 and Nurse #2 on 06/13/23 at 2:56 PM, the access cord for the light switch for the light behind the bed remained inaccessible from Resident #139's bed. A joint interview was conducted with NA #1 and Nurse #2 on 06/13/23 at 2:58 PM. Both nursing staff confirmed Resident #139 was bed bound and acknowledged that the switches on the wall were unreachable for Resident #139 from the bed. They had provided care for Resident #139 in the past 2 days but did not notice the access cord for the light switch behind the bed was broken.	F 558	on the resident's right to reside and receive services in the facility with reasonable accommodation of resident needs, specifically regarding light cords being in reach of residents. Ensuring residents can reach light cords from bed was added to daily room rounds on 06-20-2023. Monitoring: The Maintenance Director or designee will complete a weekly review of all resident room light cords to ensure they are the appropriate length weekly for one month, biweekly for a month, and monthly for one month. Additionally, department heads will be tasked to review this five days a week. The Administrator is responsible for implementing this Plan of Correction (POC) and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee for three consecutive meetings. At which time, the determination will be made if further monitoring is necessary. Recommendations for changes to the POC will occur if the facility does not maintain compliance with regulatory requirements. The POC can be changed to include additional education and monitoring to obtain and maintain substantial compliance. The completion date for this plan of correction is 06-21-2023.	

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F 558	Continued From page 5 During an interview conducted with the Maintenance Manager on 06/13/23 at 3:24 PM, he stated he did a walk through for the whole building to identify repair needs at least once monthly. Other than that, he depended heavily on the staff to report repair/maintenance needs through the electronic work order reporting system. He acknowledged that the access cord to control the switches for the light fixture behind the bed was inaccessible from Resident #139's bed. An interview was conducted with the Director of Nursing (DON) on 06/15/23 at 11:39 AM. She stated it was her expectation for all the staff to be more attentive to the residents' home enviornment. All the residents should have accessibility and full control of their light fixture all the time. An interview was conducted on 06/15/23 at 12:20 PM with the Administrator. He expected nursing staff to pay more attention to residents' home and reported repair needs to Maintenance Manager in timely manner. It was his expectation for all the residents to have accessibility and full control of the light fixtures to accommodate their needs.	F 558		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,	F 583		7/6/23

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F 583	Continued From page 6 and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to safeguard protected health information (PHI) for 1 of 5 medication carts by leaving confidential PHI unattended and exposed in an area accessible to the public (Medication cart of 100 Hall). The findings included: 1.Resident #139 admitted to the facility on 04/26/23.	F 583	F583 Facility failed to safeguard protected health information (PHI) for one of five medication carts by leaving confidential PHI unattended and exposed in an area accessible to the public. Corrective Action: Nurse #3 turned the privacy protection screen on shortly after leaving cart to assist resident with patient care. This nurse was in-serviced on The Health	

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F 583	Continued From page 7 A continuous observation was made on 06/14/23 from 8:12 AM through 8:14 AM of an unattended medication cart on the 100 Hall. Nurse #3 left the medication cart with the Medication Administration Record (MAR) in the computer exposed when she was providing care for Resident #139 in the room. The computer screen showed the name, picture, and other PHI of Resident #139. Nurse #3 returned to the medication cart approximately 2 minutes later at 8:14 AM to close the computer partially to about a 30 degrees angle without turning on the privacy protection screen. Then, she returned to Resident #139's room. She returned to the medication cart again about 5 minutes later at 8:19 AM and turned on the privacy protection screen. During an interview conducted on 06/14/23 at 8:20 AM, Nurse #3 explained she was distracted by Resident #139 who asked for assistance when she was doing medication pass. She stated residents' PHI should not be exposed or left unattended and acknowledged that it was her oversight. She stated she had Health Insurance Portability and Accountability Act (HIPAA) training at least once yearly and the last training was completed a few months ago. An interview was conducted with Unit Manager #2 on 06/14/23 at 9:19 AM. She stated nursing staff should turn on the privacy protection screen when they were away from the medication cart to avoid exposing residents' PHI. It was her expectation for all the nursing staff to follow HIPAA guidelines when working in the facility. During an interview conducted on 06/15/23 at 11:39 AM, the Director of Nursing (DON) expected all the staff to safeguard residents' PHI	F 583	Insurance Portability and Accountability Act of 1996 (HIPPA). The in-service took place on 06-16-2023. Others Affected: The Director of Nursing or designee completed a random audit of 100% Medication Administration Record Computers on 6-30-23 and 7-3-23 during medication pass for exposure of unattended exposure of resident privacy information. No concerns were identified during these audits. Systemic Change: Facility nurses and medication aides were in-serviced on 06-16-2023 through 07-05-2023 on HIPPA guidelines and closing or covering resident privacy information when not in direct use. Staff who did not complete the in-service by 07-05-2023 were not allowed to work until the in-service was completed. HIPPA training was added to the new hire orientation of nurses and medication aides on 7-5-23 by the Director of Nursing. Monitoring: The Director of Nursing or designee will complete a review of unattended medication carts throughout the facility to ensure that the privacy screen is being used. Five unattended carts will be observed weekly for one month, bi-weekly for one month, and then monthly for one month. The Administrator is responsible for	

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F 583	Continued From page 8 and follow HIPAA guidelines all the time. During a phone interview conducted on 06/15/23 at 12:20 PM, the Administrator stated all residents' confidential PHI should be protected. It was his expectation for all the staff to follow HIPAA guidelines when working in the facility.	F 583	implementing this Plan of Correction (POC) and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee for three consecutive meetings. At which time, the determination will be made if further monitoring is necessary. Recommendations for changes to the POC will occur if the facility does not maintain compliance with regulatory requirements. The POC can be changed to include additional education and monitoring to obtain and maintain substantial compliance. The completion date for this plan of correction is 07-06-2023.	
F 584 SS=D	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.	F 584		7/14/23

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F 584	Continued From page 9 §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 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 a door with splintered wood and exposed rough layer of wood in good repair for 1 of 11 sampled resident rooms (412). Findings included: On 6/12/23 at 10:08 AM an observation of Room #412 revealed the door at the entrance of the room was scraped with an area on the edge of the door approximately wheelchair armrest height of 2 x 1 inches was missing the outer layer of the wood with visible splinters. The bottom corner edge of the door was observed with the outer layer of the wood peeled away from the door, exposing a rough, unfinished layer of the door.	F 584	F584 Facility failed to maintain a door with splintered wood and an exposed rough layer of wood in good repair for 1 of 11 sampled resident rooms. Corrective Action: The splintered door was reported to facility Maintenance Director and Administrator on 06-15-2023. The door was immediately fixed with a door sleeve by the Maintenance Director on 06-15-2023. The Maintenance Director was in-serviced on resident's right to maintain a safe, clean, comfortable, and homelike environment, with specific focus on	

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F 584	Continued From page 10 On 6/13/23 at 2:35 PM an observation for Room #412 revealed the door was unchanged from the previous observation on 6/12/23. On 6/15/23 at 11:15 AM an observation of Room #412 revealed the door was unchanged from the previous observation on 6/12/23 and 6/13/23. On 6/15/23 at 11:40 AM the Administrator and Maintenance Supervisor were shown the damaged door in Room #412. The Maintenance Supervisor stated he was not aware of the damaged door, and it had not been reported to him. He stated he completed monthly rounds of the rooms and had not observed the damage to the door in Room #412. The Administrator stated the Administrative Staff completed daily rounds and normally reported any concerns during their daily morning meetings and damage to the door in Room #412 had not been reported. On 6/15/23 at 11:46 AM the Administrator stated that the door of Room #412 should have been reported to Maintenance and repaired.	F 584	maintaining door integrity by the Administrator. Others Affected: The Maintenance Director completed an audit of doors in the facility for splintered wood or poor door integrity on 06-15-2023. No material findings noted. Systemic Change: An in-service was initiated on 06-15-2023 through 07-13-2023 with the Maintenance Director, other Department Heads, and all facility staff and contract staff on reporting environmental issues by the Administrator. Staff could not work after 07-13-2023 if they were not in-serviced. Room rounds are conducted 5 days a week by the Department Heads on areas of room integrity of cleanliness, working order and resident overall needs. Door integrity was added to the room round document used to report any non-patient care needs on 7-5-23 by the Administrator. Monitoring: The Maintenance Director or designee will complete a weekly review of all resident room doors to ensure for integrity weekly for one month, biweekly for a month, and monthly for one month. Additionally, department heads will be tasked to review this for five days a week on room rounds. The Administrator is responsible for implementing this Plan of Correction (POC) and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee for three consecutive meetings. At which time, the determination will be made if further monitoring is necessary.	

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F 584	Continued From page 11	F 584	Recommendations for changes to the POC will occur if the facility does not maintain compliance with regulatory requirements. The POC can be changed to include additional education and monitoring to obtain and maintain substantial compliance. The completion date for this plan of correction is 07-14-2023.	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756		7/12/23

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F 756	Continued From page 12 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, and Medical Director (MD), the Consultant Pharmacist failed to identify drug irregularities and provide recommendations for 1 of 5 residents reviewed for unnecessary medications (Residents #34). The findings included: Resident #34 was admitted to the facility on 05/31/23 with diagnoses including diabetes mellitus. Review of the physician's orders dated 05/31/23 revealed Resident #34 had an order to receive 10 units of Basaglar insulin subcutaneously once daily at bedtime for diabetes. The order specified to hold the insulin when Resident #34's capillary blood glucose (CBG) was lower than 150 milligrams per deciliter (mg/dL). Review of medical records revealed the Consultant Pharmacist had conducted a new admission medication regimen review (MRR) for Resident #34 on 06/05/23 and a subsequent	F 756	F756 Facility Consultant Pharmacist failed to identify drug irregularities and provide recommendations for unnecessary medications for resident #34. Corrective Action: On 06-15-2023, the Medical Provider, Resident and Resident family were notified of the medication error by the Director of Nursing (DON). The Medical Provider evaluated the resident on 06-15-2023. New orders received to discontinue Basaglar insulin parameters were obtained from the Medical Provider and an order given to check Hemoglobin A1C (HBGA1C). The DON entered the orders into the Electronic Medical Record (EMR). The HBGA1C was obtained by the lab on 06-15-2023. The resident displayed no ill effects. Others Potentially Effected: The Consultant Pharmacist's supervisor conducted an audit of all insulin orders for	

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F 756	Continued From page 13	F 756		

monthly MRR on 06/12/23. He did not identify any drug irregularities and did not make any specified recommendations to the physician or nursing staff.

The admission Minimum Data Set (MDS) dated 06/07/23 assessed Resident #34 with intact cognition and indicated she had received insulin daily in the 7-day assessment periods.

The diabetic care plan initiated on 06/08/23 for Resident #34 revealed she had the potential for complications related to diagnosis of diabetes. The goal was to remain free of signs of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) through the next review period. Intervention included to administer medications as ordered.

A review of medication administration record (MAR) for May 2023 through June 2023 indicated Resident #34 had received 10 units of Basaglar insulin subcutaneously at bedtime from 3 different nurses, 10 times within 15 days when her CBGs were less than 150 mg/dL prior to insulin administration on the following nights:

- 05/31/23 when CBG = 135 mg/dL
- 06/01/23 when CBG = 138 mg/dL
- 06/02/23 when CBG = 127 mg/dL
- 06/03/23 when CBG = 122 mg/dL
- 06/07/23 when CBG = 100 mg/dL
- 06/09/23 when CBG = 114 mg/dL
- 06/10/23 when CBG = 92 mg/dL
- 06/11/23 when CBG = 144 mg/dL
- 06/12/23 when CBG = 120 mg/dL
- 06/14/23 when CBG = 88 mg/dL

During a phone interview conducted on 06/15/23

parameters to ensure parameters were correct for the month of June, 2023. The audit was initiated on 07-06-2023 and will be completed by 07-12-2023. Irregularities will be reported to the attending physician, the facility's medical director, and the director of nursing (DON) who made the corrections or recommendations per the physician orders.
Systemic Change:
The Consultant Pharmacist was inserviced by his supervisor on 07-06-2023 to ensure that recommendations have been carried out according to the physician order and to identify and report all drug irregularities to the physician and nursing in a timely manner. The focus of the inservice was to ensure that insulin orders with parameters are reviewed and reported appropriately.
Monitoring:
The Consultant Pharmacist's supervisor will complete monthly audits of all insulin orders for parameters to ensure parameters are correct and the accuracy of reporting drug irregularities for three months.
The Administrator is responsible for implementing this Plan of Correction (POC) and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee for three consecutive meetings. At which time, the determination will be made if further monitoring is necessary.
Recommendations for changes to the POC will occur if the facility does not maintain compliance with regulatory requirements. The POC can be changed

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F 756	Continued From page 14 at 10:10 AM. Nurse #3 stated she worked second shift on 06/03/23 and 06/09/23 and confirmed she had administered Basaglar insulin for Resident #34 in both shifts. She explained she did not notice the perimeter set by the physician and acknowledged that the insulin should be held when Resident #34's CBG was less than 150 mg/dL. A phone interview was conducted with Nurse #4 on 06/15/23 at 10:24 AM. She stated she worked second shift on 06/02/23 and 06/12/23 and confirmed she had administered Basaglar insulin for Resident #34 in both shifts. She explained she did not notice the perimeter set by the doctor in the computer and acknowledged that the insulin should be held when Resident #34's CBG was less than 150 mg/dL, as ordered by the physician. During an interview conducted on 06/15/23 at 10:51 AM, Resident #34 stated she had received Basaglar insulin once every night since her admission on 05/31/23. She denied having any episode of low blood sugar so far. A phone interview was conducted on 06/16/23 at 10:19 AM with the Consultant Pharmacist. He stated he had reviewed Resident #34's medication regimen twice since her admission. However, he did not make any recommendation to the physician or nursing so far. He noted Resident #34 was taking Basaglar insulin and her blood glucose levels were well controlled. He did not notice the perimeter set by the physician to hold insulin when the CBG was less than 150 mg/dL. During a phone interview conducted on 06/16/23 at 10:42 AM, the MD stated it was his expectation	F 756	to include additional education and monitoring to obtain and maintain substantial compliance. The completion date for this plan of correction is 07-12-2023.	

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F 756	Continued From page 15 for the Consultant Pharmacist to identify all drug irregularities during MRRs and alert the physician and nursing staff in a timely manner. A phone interview was conducted with the Administrator on 06/16/23 at 10:47 AM. He expected the Consultant Pharmacist to identify and report all drug irregularities to the physician and nursing in timely manner. During a phone interview conducted on 06/16/23 at 11:04 AM, the Director of Nursing stated it was her expectation for the Consultant Pharmacist to identify and document all drug irregularities during MRRs and make recommendation to the physician and nursing staff in timely manner.	F 756		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, and Medical Director (MD), the facility failed to prevent a significant medication error when nurses failed to follow physician's parameter as ordered during insulin administration. As a result, Resident #34 received 10 doses of unnecessary Basaglar insulin within 15 days. This affected 1 of 5 residents reviewed for unnecessary medications (Resident #34). The findings included: Resident #34 was admitted to the facility on	F 760	F760 Resident #34 had an order for Basaglar insulin 10 units subcutaneous at bedtime, hold for blood sugar less than 150. On several occasions since 05-31-2023, Resident #34 received the 10 units of Basaglar insulin when blood sugar was less than 150. Corrective Action: On 06-15-2023, the Medical Provider, Resident and Resident family were notified off the medication error by the Director of Nursing (DON). The Medical	6/16/23

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F 760	Continued From page 16 05/31/23 with diagnoses including diabetes mellitus. Review of the physician's orders dated 05/31/23 revealed Resident #34 had an order to receive 10 units of Basaglar insulin subcutaneously once daily at bedtime for diabetes. The order specified to hold the insulin when Resident #34's capillary blood glucose (CBG) was lower than 150 milligrams per deciliter (mg/dL). The admission Minimum Data Set (MDS) dated 06/07/23 assessed Resident #34 with intact cognition and indicated she had received insulin daily in the 7-day assessment periods. The diabetic care plan initiated on 06/08/23 for Resident #34 revealed she had the potential for complications related to diagnosis of diabetes. The goal was to remain free of signs of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) through the next review period. Intervention included to administer medications as ordered. A review of the medication administration records (MARs) for May 2023 through June 2023 revealed Resident #34 had received 10 units of Basaglar insulin subcutaneously at bedtime from 3 different nurses, 10 times within 15 days when her CBGs were less than 150 mg/dL prior to insulin administration on the following nights: - 05/31/23 when CBG = 135 mg/dL - 06/01/23 when CBG = 138 mg/dL - 06/02/23 when CBG = 127 mg/dL - 06/03/23 when CBG = 122 mg/dL - 06/07/23 when CBG = 100 mg/dL - 06/09/23 when CBG = 114 mg/dL	F 760	Provider evaluated the resident on 06-15-2023. New orders received to discontinue Basaglar insulin parameters were obtained from the Medical Provider and an order given to check Hemoglobin A1C (HBGA1C). The DON entered the orders into the Electronic Medical Record (EMR). The HBGA1C was obtained by the lab on 06-15-2023. The resident displayed no ill effects. Systemic Change: On 06-15-2023, a 100% audit was conducted by the Unit Manager for all residents receiving insulin with parameters. Any resident found to have been affected by this deficient practice was addressed and corrected on 06-15-2023. The resident, resident representative and Medical Provider were notified on 06-15-2023 by the DON and the resident was evaluated by the provider. Any new orders were entered into the EMR by the DON on 06-15-2023. An inservice was initiated on 06-15-2023 on following parameters for insulin to all licensed nurses. This inservice was conducted by the Assistant Director of Nursing (ADON) and completed the same day. Licensed nurses were not allowed to work until this had been completed. This education has been entered into the new hire orientation for licensed nurses on 06-15-2023 and will be reviewed by the ADON or designee. Monitoring:	

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F 760	Continued From page 17 - 06/10/23 when CBG = 92 mg/dL - 06/11/23 when CBG = 144 mg/dL - 06/12/23 when CBG = 120 mg/dL - 06/14/23 when CBG = 88 mg/dL Further review of MARs revealed Resident # 34's morning blood glucose levels were within the normal limits. It ranged from 94 mg/dL to 168 mg/dL. During a phone interview conducted on 06/15/23 at 10:10 AM. Nurse #3 stated she worked second shift on 06/03/23 and 06/09/23 and confirmed she had administered Basaglar insulin for Resident #34 in both shifts. She explained she did not notice the parameter set by the physician and acknowledged that the insulin should be held when Resident #34's CBG was less than 150 mg/dL. A phone interview was conducted with Nurse #4 on 06/15/23 at 10:24 AM. She stated she worked second shift on 06/02/23 and 06/12/23 and confirmed she had administered Basaglar insulin for Resident #34 in both shifts. She explained she did not notice the parameter set by the doctor in the computer and acknowledged that the insulin should be held when Resident #34's CBG was less than 150 mg/dL, as ordered by the physician. During an interview conducted on 06/15/23 at 10:51 AM, Resident #34 stated she had received Basaglar insulin once every night since her admission on 05/31/23. She denied having any episode of low blood sugar so far. A phone interview was conducted with the MD on 06/15/23 at 11:15 AM. He explained Basaglar was a long-acting insulin, and it could affect blood	F 760	The DON or designee will conduct five medication pass observations on licensed nurses administering insulin weekly for four weeks, then three licensed nurses weekly for four weeks, then one licensed nurses monthly for one month. Focus will be placed on insulin orders with parameters. The DON or designee will conduct daily audits for four weeks for all residents receiving insulin with parameters to ensure insulin is being administered according to the order, then twice a week for four weeks, then monthly for one month. The Administrator is responsible for implementing this Plan of Correction (POC) and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee for three consecutive meetings. At which time, the determination will be made if further monitoring is necessary. Recommendations for changes to the POC will occur if the facility does not maintain compliance with regulatory requirements. The POC can be changed to include additional education and monitoring to obtain and maintain substantial compliance. The completion date for this plan of correction is 06-16-2023.	

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F 760	Continued From page 18 glucose levels in the morning. He stated Resident #34's morning blood glucose levels were within the normal ranges in the past 15 days. He stated he did not understand why nurses would not follow the parameter attached to the order. It was his expectation for nurses to follow his order and parameter all the time. During an interview conducted on 06/15/23 at 11:39 AM, the Director of Nursing acknowledged that the incident was a medication error, and it could potentially be a significant medication error. It was her expectation for all the nursing staff to follow physician's order and parameter all the time. An interview was conducted on 06/15/23 at 12:20 PM. The Administrator stated the incident was a significant medication error as it could trigger hypoglycemia. He expected nursing staff to pay attention to the physician's order and ordered parameters when administering medications. It was his expectation for all the nursing staff to follow the physician's order all the time.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		7/6/23

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F 761	Continued From page 19 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews, the facility failed to store an opened nasal spray in a safe and secure manner for 1 of 3 residents review for medication storage. (Resident #18) The findings included: Review of facility's medication storage policy and procedure dated 09/30/22 indicated all drugs and biologicals should be stored in a safe, secure, and orderly manner to prevent the possibility of mixing medications of several different residents. Resident #9 admitted to the facility on 04/27/17 with diagnosis included seasonal allergies. Resident #18 admitted to the facility on 10/10/20. During an observation conducted on 06/12/23 at 11:12 AM for Resident #18, a bottle of opened fluticasone nasal spray was left unattended on top of the bed side table in the room.	F 761	F761 Facility failed to store drugs and biologicals appropriately as evidence by a bottle of opened fluticasone nasal spray left unattended on top of bedside table in resident #18 room. Corrective Action: Medication Aide #1 was notified by the surveyor and immediately removed and disposed of opened nasal spray. Nurse #1, who last administered the medication on 06-11-2023 was inserviced on proper labeling and drug storage on 06-12-2023. On 06-12-2023, a 100% audit was completed by the Assistant Director of Nursing and Unit Manager of each resident□s room for appropriate medication storage. No findings were noted. Systemic Change: An inservice was initiated by the Assistant Director of Nursing (ADON) on 06-12-2023 through 07-05-2023 to nurses and	

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F 761	Continued From page 20 An interview was conducted with Resident #18 on 06/12/23 at 11:15 AM. She did not know a nasal spray was left unattended in her room and the length of time it had been sitting on her bed side table. She added the nasal spray was not for her and did not know why it was left in her room. During an interview conducted on 06/12/23 at 11:18 AM, Medication Aide #1 denied she had left the nasal spray in Resident #18's room. She stated did not notice the nasal spray was left unattended in Resident #18's room when she did medication pass that morning. She explained the nasal spray was not for Resident #18. It is for Resident #9 who stayed across the hall. She indicated the nasal spray was last used on the evening of 06/11/23 according to the Medication Administration Records (MARs). She reported it could have been left in Resident #18's room accidentally by the nurse who worked on 06/11/23 night. Review of MARs confirmed the fluticasone nasal sprays was prescribed for Resident #9. It was last administered by Nurse #1 on 06/11/23 at 9:00 PM. Phone interview with Nurse #1 was attempted but unsuccessful. He was unavailable to answer the call and did not return the call. An interview was conducted with the Unit Manager #1 on 06/12/23 at 11:34 AM. She stated nursing staff should not leave any medications unattended in resident's rooms. She confirmed the fluticasone nasal sprays was for Resident #9 and did not know why it was left in Resident #18's room. It was her expectation for the facility to	F 761	medication aides on proper labeling and drug storage, and not leaving medications in residents rooms unattended in accordance with the facility□s policy. Medication aides and nurses who did not complete the inservice by 07-05-2023 were not allowed to work until the inservice was completed. Education on proper labeling, drug storage and not leaving medications in residents rooms unattended will be added to the general orientation for medication aides and licensed nurses on 07-01-2023 by the Director of Nursing. Monitoring: The Director of Nursing or designee will conduct a weekly audit of 10 resident rooms to ensure no medications at bedside. Any variances will be addressed at that time. This audit will be conducted weekly for 4 weeks, biweekly for a month and then once a month for one month. The Administrator will report on this Plan of Correction (POC) to Quality Assurance Performance Improvement (QAPI) committee for three consecutive meetings until the POC is completed. Recommendations for changes to the POC will occur if the facility does not maintain compliance with regulatory requirements. The POC can be changed to include additional education and monitoring to obtain and maintain substantial compliance. The plan of correction was completed 07-06-2023.	

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F 761	Continued From page 21 remain free of unattended medication. During an interview conducted on 06/15/23 at 11:39 AM, the Director of Nursing (DON) expected nursing staff to follow the policy and procedure of medication storage and keep the facility free of unattended medications. An interview was conducted with the Administrator on 06/15/23 at 12:20 PM. He expected nursing staff to be more attentive to resident's home environment. It was his expectation for the facility to remain free of unattended medication.	F 761		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at	F 867		6/30/23

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 22 §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.	F 867		

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F 867	Continued From page 23 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its	F 867		

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F 867	Continued From page 24 activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the annual recertification survey conducted on 10/14/21. This was for one deficiency originally cited in October 2021 in the area of Safe/Clean/Comfortable/Homelike Environment and was subsequently recited on the current annual recertification survey of 06/16/23. The duplicate citation during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag was cross referenced to: F584: During the annual recertification survey conducted on 06/16/23, the facility failed to repair a door with splintered wood and exposed rough layers of wood in good condition for 1 of 11 sampled resident rooms (412).	F 867	F867 The facility's Quality Assurance Committee failed to maintain implemented procedures and monitor the interventions the facility put in place following the annual recertification survey conducted on 10/14/2021. The facilities Quality Assurance and Performance Improvement committee put into place a plan of correction following the annual recertification on 10/14/21 in the area of FTAG 584, Safe/Clean/Comfortable/Homelike Environment. This Plan of correction was dated 11/7/21 with a completion of all audits ending 2/7/22. During the annual recertification survey conducted on 06/16/2023, the facility failed to repair a door with splintered wood in 1 of 11 sampled rooms (412) (FTAG 584 Safe/Clean/Comfortable/Homelike Environment). A plan of correction was put into place on 11/7/21 and was completed on 2/7/22. This plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance	

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F 867	Continued From page 25 During the annual recertification survey conducted on 10/14/21, the facility failed, to maintain the base of a toilet in sanitary condition, maintain a bedside commode in good condition, maintain doors in good condition and maintain wheelchair brakes in sanitary condition reviewed for a safe, clean, comfortable, and homelike environment. An interview was conducted on 06/16/23 at 1:57 PM with the Administrator. The Administrator revealed he started in his position in April 2023 and had met twice with the Quality Assurance Committee and they continue to meet monthly. The Administrator explained the facility reviewed the previous five 5 years of survey results and the concerns with the environment was ongoing. He revealed room rounds were done Monday through Friday to capture environment issues and included to check the doors in resident rooms for repair needs. He revealed him, the Maintenance Supervisor, and Environmental Services walk around once week to look for life safety concerns and check the condition of the building and look for damaged doors.	F 867	Committee meetings for a defined period of time. Monitoring of the plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued. The Administrator initiated an in-service to all administrative staff on 06/29/2023 regarding Quality Assurance Performance Improvement (QAPI) process including identifying and prioritizing quality deficiencies, systemically analyzing causes of quality deficiencies, developing, and implementing corrective action or performance improvement activities. This in-service included accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff worked util they received appropriate education. The QAPI committee will review the compliance audits for FTAG 584 to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction. Date of Compliance: 06/30/2023	

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