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 09/11/2024

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 09/08/24 through 09/11/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # KKB711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/08/24 through 09/11/24. Event ID #KKB711. The following intake was investigated: NC00220674. 2 of the 2 complaint allegations did not result in a deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to assess the ability of a resident to self-administer medication for 1 of 1 resident with medication observed in the room (Resident #84). Findings included: Resident #84 was admitted to the facility 08/07/24. Review of the medical record revealed no documentation that Resident #84 was assessed for self-administration of medications.	F 554	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to assess the ability of a resident to self-administer medication for 1 of 1 resident with medication observed at the bedside. On 9/11/24 the Director of Nursing removed the nail fungus pen from Resident #84's bedside. Address how the facility will identify other	9/12/24

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

Electronically Signed | 10/03/2024

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F 554	Continued From page 1 The admission Minimum Data Set (MDS) assessment dated 08/10/24 revealed Resident #84 was moderately cognitively impaired. Review of Resident #84's physician orders revealed no current order for the use of an anti-fungal medication. Observations of Resident #84's overbed table on 09/09/24 at 9:35 AM, 09/10/24 at 3:36 PM, and 09/11/24 at 11:20 AM revealed a 3 milliliter (ml) medication pen with the active ingredient tolnaftate (antifungal medication) 1% lying on top of the table. An interview with Resident #84 on 09/09/24 at 9:35 AM revealed he usually applied the anti-fungal medication daily to treat fingernail fungus. An observation of Resident #84's fingernails on both hands on 09/09/24 at 9:35 AM revealed his fingernails had a yellowish discoloration with a ripple-like texture. In an interview with the Director of Nursing (DON) on 09/11/24 at 1:05 PM she confirmed the anti-fungal medication pen would be considered a medication and should not be left on Resident #84's overbed table. She stated staff rounded on resident rooms daily to check for medications left in resident rooms and that it was overlooked. A follow-up interview with the DON on 09/11/24 at 2:20 PM revealed if a resident wanted to self-administer medication they had to be assessed as safe to self-administer medication, a physician order was obtained, and the medication would be stored in the locked top drawer of the	F 554	residents having the potential to be affected by the same deficient practice: Current residents are at risk for this deficient practice. On 9/8/24, the Director of Nursing/ Unit Manager began auditing current residents' rooms to determine if medications were identified at the bedside. No additional medications were found. On 9/11/24 an ad hoc QAPI was held to discuss the deficient practice and initiate a plan of correction with auditing tools. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 9/11/24 the Director of Nursing/Unit Manager educated all nursing staff that residents can not have medications at the bedside unless they have been assessed to self-administer meds. Staff were instructed to report and remove any medications at resident bedside to the Director of Nursing or the Administrator if they do not have an order to self-administer. On 9/11/24 the Director of Nursing/ Unit Manager begin educating the facility staff to include the therapists, housekeeping/laundry staff, dietary staff, social services staff, administrative staff, weekend staff, and prn staff on reporting identified medications at resident's bedside to the licensed nurse. The Director of Nursing (DON)/ Unit Manager will ensure that all current staff will not be allowed to work until the education is	

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F 554	Continued From page 2 resident's dresser. The DON confirmed Resident #84 had not been assessed to self-administer medication. An interview with the Administrator on 09/11/24 at 2:38 PM revealed medications should not be left in a resident's room without a physician order. He stated staff rounded on resident rooms daily to check for medications left in the room and he felt the anti-fungal pen was overlooked because it looked similar to a writing pen.	F 554	completed. The Director of Nursing/ Unit Manager will ensure newly hired staff will receive education during the facility orientation prior to working. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing will complete audits weekly for 4 weeks and monthly for 2 months to ensure continual compliance. The Director of Nursing will report the findings monthly for at least 6 months to the Quality Assurance Performance Improvement (QAPI) committee for review and/or revision. The date of compliance is 9/12/24.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		9/12/24

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F 812	Continued From page 3 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff, the facility failed discard expired leftover food ready for use in 1 of 1 walk-in cooler and failed to ensure the floor in the dry food storage area was clean in 1 of 1 kitchen. These practices had the potential to affect food served to residents. Findings included: a. During a walk-through observation of the kitchen and interview with the Assistant Dietary Manager (DM) on 9/8/24 at 8:52 AM through 9:45 AM revealed a 12-ounce package of sliced bologna with an expiration date of 4/16/24 being stored in the walk-in cooler ready for use with no resident name or or date on the package. The Assistant DM revealed she removed the bologna from freezer on 9/6/24 so it could thaw for a resident who had requested it and forgot to label and date the package when it was removed. b. An observation and interview conducted with the DM on 9/8/24 at 9:45 AM revealed the tile floor in the dry food storage area had crumb-like debris scattered underneath the metal shelving where food was being stored. A wrapped nutrition bar and can of soda was left on the floor underneath the shelving. The tile baseboard and floor underneath the metal shelving by the wall throughout the dry food storage area appeared dirty with thick black colored buildup of debris. The DM revealed the Dietary Aides swept and mopped the floors in the dry storage area daily. She observed the floors throughout the dry	F 812	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to discard expired leftover food ready for use in 1 of 1 walk-in cooler and failed to ensure the floor in the dry food storage area was clean in 1 of 1 kitchen. On 9/8/24 the Dietary Manager disposed of the expired bologna that belonged to a specific resident and not for use by all residents. The facility purchased a new pack of bologna for the affected resident. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents have the potential to be affected by this deficient practice. The Dietary Manager completed a 100% audit of food storage including refrigerators, freezers, and dry storage rooms to ensure all food was within usage dates, properly stored, labeled, and items were properly disposed of as identified. On 9/11/24 an ad hoc QAPI was held to discuss the deficient practice and initiate a plan of correction with auditing tools. Address what measures will be put into	

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F 812	Continued From page 4 storage area underneath the metal shelving were dirty with a thick black colored buildup of debris and revealed Dietary Aide staff probably had a hard time reaching that area of the floor due to the metal shelving was attached to the wall making it difficult to reach. During an interview on 09/10/24 at 1:18 PM Dietary Aide #1 confirmed she worked and was the person who swept and mopped the floor in the dry food storage area by the end of her shift on 9/7/24. Dietary Aide #1 revealed she had scrubbed the area and was able to reach underneath the metal shelving and to her the floor appeared clean. She revealed she did not observe a thick buildup of black colored debris on the tile floor. During an interview on 09/11/24 at 2:32 PM the Administrator revealed the bologna was requested by one resident and not in use of all residents. The Administrator revealed he wanted Dietary staff to do their best to keep the kitchen clean.	F 812	place or systemic changes made to ensure that the deficient practice will not recur: On 9/8/24 the Dietary Manager completed education with all current dietary staff on proper food procurement, storage, preparation, labeling, and ensuring all floors are swept and mopped with no debris left on floors or under shelving. Any staff that did not receive the education will not be allowed to work until education has been completed. New facility dietary staff will complete education prior to working their first shift. The Dietary Manager will be responsible for ensuring education is received. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Dietary Manager or designee will audit refrigerators, freezers, dry storage, and nourishment rooms to ensure all food was within usage dates, properly stored, and labeled and all floors are clean for three (3) times a week for four (4) weeks and weekly for eight (8) weeks. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness	

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F 812	Continued From page 5	F 812	of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 9/12/24	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and resident interview, the facility failed to ensure a call light was functioning properly for 1 of 1 resident who required staff assistance for activities of daily living (Resident #80). The findings included: Resident #80 was admitted to the facility on 07/14/23. The annual Minimum Data Set assessment dated 06/10/24 revealed Resident #80 had intact cognition. An observation and interview was conducted with Resident #80 on 09/08/24 at 11:38 AM. Resident #80 was lying in bed trying to get a hold of the pancake call light (round and flat that activates when touched) that was attached to the bed	F 919	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to ensure a call light was functioning properly for 1 of 1 resident who required staff assistance for activities of daily living. For Resident #80, the malfunctioning call light was replaced on 9/8/24 by the Maintenance Director. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents residing in the facility have the potential to be affected the alleged deficient practice. On 9/8/2024 a 100% audit of all resident call lights was	9/12/24

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F 919	Continued From page 6 sheet and was hanging off the right side of the bed. Resident #80 stated she was wanting to sit up on the side of the bed and needed staff assistance. When Resident #80 attempted to press the call light, the light on the wall panel in her room and the light over her doorway in the hall did not activate. Nurse Aide (NA) #1 was notified Resident #80 was needing staff assistance and proceeded into Resident #80's room. A subsequent observation of the call light in Resident #80's room was conducted on 09/08/24 at 3:15 PM. Resident #80 was lying in bed, sleeping soundly, with the call light on the bed directly beside her. When the call light was pressed, the light on the wall panel in her room and the light over her doorway in the hall did not activate. Also, the call light for the empty bed that was in Resident #80's room was checked and the light on the wall panel and over the doorway did not activate. During an interview on 09/10/24 at 9:56 AM, NA #1 confirmed she was assigned to provide care to Resident #80 during first shift on 09/08/24 and was not aware that Resident #80's call light was not functioning. NA #1 explained she was in and out of Resident #80's room frequently on 09/08/24 and Resident #80 had not voiced any concerns to her about the call light. NA #1 stated typically when a call light was malfunctioning, there was an indicator on the light above the doorway and maintenance would be notified but she had not noticed anything. An observation and interview was conducted with the Weekend Nurse Supervisor on 09/08/24 at 3:15 PM. The Weekend Nurse Supervisor	F 919	completed by the Maintenance Director to ensure all call lights were functioning properly. The results of the audit revealed: no other call lights were identified to be broken and or not functioning properly. On 9/8/24 an ad hoc QAPI meeting was held to discuss deficient practice and a plan of correction with monitoring tool was put in place. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 9/8/24, the Administrator and Director of Nursing educated all staff on process for reporting when call lights are not functioning properly and to follow up to ensure they have repaired or replaced. Staff were also educated to supply residents with a bell to call for assistance in the event the call light isn't working. Staff will not be allowed to work until education has been completed. On 9/8/24 the Administrator informed the Assistant Director of Nursing she would be in charge of adding the education to the new hire orientation education. No new staff will be allowed to work until education has been completed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 919	Continued From page 7 confirmed the light on the wall panel in the room or over the doorway did not activate when Resident #80's call light or the call light for the empty bed in the room were pressed. She was unaware the call lights were not working in Resident #80's room. She stated Resident #80 could use her call light for assistance and if they had known her call light was not working, they could have given Resident #80 a hand bell to use until the call light was repaired. She stated the Maintenance Director was in the facility today and she would notify him of the issue. An observation and interview was conducted with the Maintenance Director on 09/08/24 at 3:25 PM. The Maintenance Director confirmed the light on the wall panel in the room or over the doorway did not activate when Resident #80's call light or the call light for the empty bed in the room were pressed. The Maintenance Director explained when repairs were needed, typically nursing staff would enter a work order in the computer system or notify him verbally. The Maintenance Director stated he was unaware the call lights were not working in Resident #80's room and he had not received any work order or verbal notification from nursing staff. During a follow-up observation and interview on 09/09/24 at 9:32 AM, Resident #80 stated using her call light was "a joke" because she would push the call light when assistance was needed but it would take staff over a half an hour to respond during the day time, if at all, and at night, no one would respond. An observation of Resident #80's call light revealed when the call light was pushed, the light on the wall panel in her room and the light over the doorway in the hall both activated.	F 919	The Administrator or Maintenance Director will monitor call light function utilizing the QA Tool for call lights to ensure call lights are functioning properly. This will be completed weekly x 4 weeks then monthly for 2 months. Reports will be presented to the QAPI committee by the Administrator to ensure corrective action is initiated as appropriate. Date of Compliance: 9/12/24	

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F 919	Continued From page 8 During a follow-up interview on 09/10/24 at 3:52 PM, the Maintenance Director revealed he had been in his current position for 3 months. He stated he made daily rounds of resident rooms to check the water temperature and also checked to see if the call lights were functioning properly. The Maintenance Director explained he did not document his daily rounds or the rooms he checked if there were no issues identified and only documented if repairs were made. He could not recall the last time Resident #80's call light was checked for functioning. During an interview on 09/10/24 at 3:58 PM, the Administrator stated administrative staff members had assigned rooms for them to make daily rounds. During the daily rounds, he explained they used a checklist to guide observations and note any identified concerns which included checking the call lights to ensure they were working but they did not keep the checklists of the daily rounds that were completed. The Administrator stated Resident #80 was someone who used her call light frequently and he would have assumed that nursing staff would have noticed her call light was not working on 09/08/24 and put a work order into the facility system for maintenance to repair.	F 919		