PRINTED: 03/27/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		71. 501251			С			
		345463	B. WING			l) 23/2017	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	23/2017	
					00 THOMPSON STREET			
LIFE CAR	E CENTER OF HENDERS	SONV			ENDERSONVILLE, NC 28792			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 000	INITIAL COMMENTS		F	000				
	No deficiencies were	cited as a result of the						
	complaint investigation	on Event ID #SS1D11.						
F 250	483.40(d) PROVISIO	N OF MEDICALLY	F:	250			3/23/17	
SS=D	RELATED SOCIAL S	ERVICE						
	(d) The facility must p	provide medically-related						
	social services to atta	in or maintain the highest						
	practicable physical,	mental and psychosocial						
	well-being of each res	sident.						
	This REQUIREMENT	is not met as evidenced						
	by:							
		ns, staff and resident			A. Resident found to be affected by			
	interviews, the facility				alleged deficient practice: Resident #11	16		
	appointment for ment				was found to have a psych. referral			
		psychological services as			consult dated 1/13/17 for depression.			
		ry care provider for 1 of 4			Psych referrals were reviewed with			
	sampled residents (R	esident #116).			Clinical Psychologist on 2/22/17 and			
					resident #116 was seen by the			
	Findings included:				Psychologist that day.			
					B. Residents that have a potential to be	9		
		dmitted to the facility on			affected: All residents that have psych.			
	_	es of chronic respiratory			referrals ordered have potential to be			
	failure, depression, a	nd anxiety disorder.			affected.	1_		
	D	- d - dt-ddf			C. Re-education on process for referral			
		ed a doctor's order for			with Social Services Director completed	נ		
		1/13/17, for psych consult			and reviewed with the Psychologist,			
	for depression.				Executive Director and Director of			
	The admission Minim	um Data Set (MDS) dated			Nursing. D. All residents with psych. services			
		resident was cognitively			referrals will be reviewed by our Social			
		r behavior issues. The MDS			Services Director and forwarded to the			
		ident had received 7 days of			Psychologist. Orders will be reviewed in	n		
	an antidepressant me	-			daily morning meetings to ensure no			
	a				psych. orders are missed. Social Service	ces	 	
	A care plan dated 1/1	9/17 indicated Resident			Director will keep a daily Referral Track			
	•	dverse effects from the			Log to ensure residents have been see			
		epressant medication.			in a timely manner. Once psych. service			
		<u> </u>						
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE	-	(X6) DATE	

03/17/2017

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

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/23/2017	
		345463	B. WING			
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV				STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET HENDERSONVILLE, NC 28792		2/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 250	#116 had received many had an order for psychologist was suresidents on his next indicated that Residents on his next indicated there had be with the facility and he consult order. The psychologist indicated with the facility and he consult order.	d not indicate that Resident nental health services or a on 2/21/17 at 2:50 PM, ated she had not received she was admitted to the DON) indicated that Resident written on 1/13/17 for psycholar worker had reviewed the ner stated she did not known ad not been seen by the DN indicated that the weekly at the facility and the sponsible for notifying him of DN 2/22/17 at 8:48 AM the indicated that Resident #116 ch services and she had not an another than the sponsible for services and she had not an another than the sponsible for services and she had not an another than the sponsed to see the referred the trisit to the facility. The SW ent #116 psych consult order	F 25	provides their progress note, Services Director will attach to order to verify resident has be. The Executive Director and/or designee will monitor all referr to assure the Social Services I notifying psych services of the treatment has begun in a time. The Executive Director and will bring tracking log to month meeting for review times 3 mo random audits will be completed month thereafter for compliance.	the psych. en seen. their als weekly Director is referral and ly manner. /or the DON sly QAPI nths and ed each	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
345463		B. WING _	B. WING		C 02/23/2017		
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV				STREET ADDRESS, CITY, ST 400 THOMPSON STREET HENDERSONVILLE, NC	ŕ	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 319 SS=D	his expectations were arranged for Resident the recommended car 483.40(b)(1) TX/SVC MENTAL/PSYCHOSO 483.40(b) Based on the assessment of a resident that- (b)(1) A resident who with mental disorder of difficulty, or who has a post-traumatic stress appropriate treatment assessed problem or practicable mental and This REQUIREMENT by: Based on observation interviews, the facility psychological evaluate by the primary care presidents (Resident #Findings included: Resident #116 was accommended.	M the Administrator stated for consult orders to be the #116 and that she received recordered by the NP. FOR DCIAL DIFFICULTIES The comprehensive dent, the facility must ensure displays or is diagnosed or psychosocial adjustment a history of trauma and/or disorder, receives and services to correct the to attain the highest displays or is diagnosed or psychosocial well-being. The improvious displayment is not met as evidenced and services as ordered for an	F 2	A. Resident to be deficient practice: I found to have depreferral was ordere referral was review Director and Psych 2/22/17 and reside Psychologist that depression of the control of the	affected by alleged Resident #116 was ression and a psych. ed on 1/13/17. Psych wed by Social Service hologist again on ent was seen by day. have potential to be	i. I. es	3/23/17
	failure, depression, an	es of chronic respiratory and anxiety disorder. ed a doctor's order for 1/13/17, for psych consult		referrals have the p All residents that h mental/psychosoci identified upon adr referral is ordered,	ial difficulties will be mission. If psych.	ed.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345463	B. WING _			03	C 2/23/2017	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV				40	REET ADDRESS, CITY, STATE, ZIP CODE 0 THOMPSON STREET ENDERSONVILLE, NC 28792	1 02	123/2017	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 319	The admission Minim 1/19/17 indicated the intact with no mood of also indicated the resident manual experience an antidepressant metassessment (CAA) in received Prozac (a mand the resident had depression and anxie Resident #116 had be for the psych issues a been ordered for depoint A care plan dated 1/1 #116 was at risk for a antianxiety and antidecare plan goal was fountoward effects from medication. The care for Resident #116 to as needed. The record review did #116 had received mpsych consult. Observations of Resifrom 1/19/17 to 1/23/ or behavior concerns During an interview of Resident #116 indication psych services since facility. The resident was maintenance of her depoint an interview of the depoint and interview of the depoint an interview of the depoint and	resident was cognitively behavior issues. The MDS dident had received 7 days of edication. The Care Area dicated the resident had redicated the resident had redication for depression) a 15 year history of ety. The CAA also revealed been hospitalized in the past and a psych consult had ression. 9/17 indicated Resident diverse effects from the repressant medication. The resident #116 to have no in the use of psychoactive plan interventions included have mental health services or a dent #116 during the survey 17 did not reveal any mood the west and not received she was admitted to the went on to say she had ant medication for years for	F3	319	forward to the Psychologist. Orders are then reviewed the following day in morning clinical meeting to ensure refeis implemented. The Executive Director and/or their designee will monitor all referrals weekly to ensure the Social Services Director is processing psych services orders and treatment has begin a timely manner. C. Log referral book is maintained by the Social Services Director and reviewed with the Psychologist on a weekly basic ensure residents are seen in a timely manner. D. The Executive Director and/or the Divill bring the Log referral book to the monthly QAPI meeting times 3 months review and random audits will be conducted each month thereafter for ensure compliance.	un ne s to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		345463	B. WING	B. WING		C 2/23/2017	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV				STREET ADDRESS, CITY, STATE, ZIP COL 400 THOMPSON STREET HENDERSONVILLE, NC 28792		2/25/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 319	services and the soc order. The DON furth why Resident #116 h	ritten on 1/13/17 for psych ial worker had reviewed the ner stated she did not know had not been seen by the	F 3 ⁻	19			
	social worker was re consult orders.	weekly at the facility and the sponsible for notifying him of					
	Social Worker (SW) had an order for psycreceived the service supposed to notify the psych consults. The psychologist was supposed to not in the psychologist was suppo	on 2/22/17 at 8:48 AM the indicated that Resident #116 ch services and she had not The SW revealed she was the psychologist of orders for SW went on to say the oposed to see the referred a visit to the facility. The SW ent #116 psych consult order the cracks.					
	Nurse Practitioner (N #116 had transitional the facility after a brid revealed the resident room and seclude he on to say that Reside therapy due to her dedisease. The NP indicates for psych consider for psych consider for lowed through supposed to have senext visit to the facility On 2/22/17 at 3:47 P	M an interview with the					
	received psych servi revealed there had b	ed that Resident #116 had not ces. The psychologist een a miscommunication the was not aware of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		(X3) DATE SURVEY COMPLETED		
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		345463	B. WING			02/	23/2017
	ROVIDER OR SUPPLIER E CENTER OF HENDER	SONV		40	TREET ADDRESS, CITY, STATE, ZIP CODE 00 THOMPSON STREET ENDERSONVILLE, NC 28792		
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F 319	was supposed to see today. On 2/22/17 at 5:26 Pl his expectations were the psych care needed recommended care of the psych care of the psych care needed recommended care of the psych service facility, and to deal with indicated that Reside and required motivation activities of daily living psych services would resident. 483.80(d)(1)(2) INFLU PNEUMOCOCCAL IN (d) Influenza and pneeded procedures to end (i) Before offering the each resident or the resident or	ychologist went on to say he Resident #116 in the facility M the Administrator stated of for the resident to receive and and to get the ordered by the NP. M an interview with the overled that Resident #116 as for adjustment to the ordered that Resident #116 had anxiety issues, on to participate with g. The NP further stated that be beneficial to the JENZA AND MMUNIZATIONS umococcal immunizations illity must develop policies sure that- influenza immunization, esident's representative garding the benefits and of the immunization;		319			3/23/17
	contraindicated or the immunized during this	mmunization is medically e resident has already been					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				, ,	(X3) DATE SURVEY COMPLETED		
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(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE		
has the opportunity (iv) The resident's m documentation that following: (A) That the resident was provided educa and potential side etimmunization; and (B) That the resident immunization or did immunization or did immunization due to refusal. (2) Pneumococcal didevelop policies and develop policies and representative receipenefits and potential immunization; (ii) Each resident is immunization, unles medically contraindial ready been immunication. (iii) The resident or that the opportunity of the resident's modocumentation that	to refuse immunization; and nedical record includes indicates, at a minimum, the tor resident's representative tion regarding the benefits fects of influenza not receive the influenza not receive the influenza medical contraindications or isease. The facility must diprocedures to ensure thate pneumococcal resident or the resident's ves education regarding the all side effects of the offered a pneumococcal s the immunization is cated or the resident has nized; the resident's representative to refuse immunization; and nedical record includes	F 33	4				
	CORRECTION ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF PROGRECTION) Continued From page has the opportunity (iv) The resident's mage documentation that following: (A) That the resident was provided educated and potential side edimmunization; and (B) That the resident immunization or didimmunization or didimmunization due to refusal. (2) Pneumococcal develop policies and develop policies and control immunization, each representative receip benefits and potential immunization; (ii) Each resident is immunization, unless medically contraindial ready been immunication thas the opportunity (iv) The resident's magent in the state of the state	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the	CONTRECTION A BUILDING	TOURTHEATTON NUMBER: 345463 345464	CONTINUED ROYALES (CITY, STATE, ZIP CODE 345463 B. WIND STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET HENDERSONVILL, IN C 28792 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES FREGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 6 has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident edither received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, unless the immunization is medically contraindicated or the resident's representative receives education regarding the benefits and potential side effects of the immunization, unless the immunization is medically contraindicated or the resident's representative receives education regarding the benefits and potential side effects of the immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (ii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident or the resident's representative has the opportunity to refuse immunization; and		

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(X4) ID	SUMMAR'	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	(EACH DEFICI REGULATORY	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 334	Continued From p	age 7	F3	334			
	was provided edu	cation regarding the benefits					
		effects of pneumococcal					
	immunization; and						
	(R) That the reside	ent either received the					
	' '	munization or did not receive					
	the pneumococca						
	contraindication o						
	This REQUIREME	ENT is not met as evidenced					
	by:						
		review, staff and physician			A. Resident found to be affected by th		
		lity failed to administer a			alleged deficient practice: Resident #2		
		neumonia) vaccine for 1 of 5			was found to have a consent signed by	-	
	#29).	d for immunizations (Resident			the responsible party for a pneumococ vaccine dated 10/14/16. Resident #29		
	#29).				expired on 2/27/17 so vaccination coul		
	Findings included				not be administered.	u	
					B. Residents that have the potential to	be	
	Review of the faci	lity's "Influenza (Flu) Vaccine,			affected: All residents admitted have the		
		ccine and Flu Outbreak			potential to be affected. All residents w	/ho	
		icy dated May 2015 revealed			have signed consents for flu or		
	· •	I vaccine is offered, upon			pneumonia vaccines have been audite		
		acility, if the resident had not			by the Staff Development Coordinator		
		ine in the past 5 years or if the			the ones that require the vaccines hav	е	
	prior vaccination s	status was unknown.			been identified. All residents with consents have received the pneumonic	2	
	Resident #29 was	readmitted to the facility on			vaccination as of 3/23/17.	a	
		noses that included Alzheimer's			C. Upon admission to our facility,		
	_	a, gastroesophageal reflux			residents will have the choice to accep	t or	
	disease (digestive	disease), dysphagia (difficulty			decline the flu and pneumonia		
	swallowing), and	esophageal stricture (narrowing			vaccinations. Educational materials will	ll be	
	of the passagewa	y from the throat to the			offered to residents and/or responsible		
	stomach).				parties upon admission by the Admissi	.on	
		1 //001			Coordinator and/or her designee. The		
		nt #29's medical record			consents will be given to the Staff	Γh a	
		consible Party signed a consent			Development Coordinator for review. T		
	1	mococcal vaccine dated			SDC will place a copy of the consent in the medical record and enter the reque		
		of Resident #29's medication d immunization records revealed			on to the Tracking Log. The SDC will the		
			1	- 1	, on to the macking bog. The ODO Will the		1

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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u> F	02/23/2017	
				400 THOMPSON STREET	_		
LIFE CAR	E CENTER OF HENDER	SONV		HENDERSONVILLE, NC 28792			
	0.00000	TITLIFIE OF DEFINITION					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)						
F 334	Continued From page	e 8	F 3	34			
	administered. Review of the quarte	rly Minimum Data Set (MDS)		write out the vaccination order receiving the physician order administer the vaccine. If the and/or responsible party is un	will resident sure if the	ey	
	dated 1/11/17 indicated Resident #29 had short and long term memory loss and severe cognitive impairment for daily decision making skills.			already have received the vac the past, the SDC will call the primary care physician to veri answer. The SDC will keep a	hospital a fy the record of	and	
	(ADON) on 2/22/17 a responsible for infect was able to hire a Sta (SDC). The ADON in had been in the proceeding received and vaccine sure if the audit had reviewed the medica for Resident #29 and documentation the probeen administered.	ne consent forms had been es administered but was not been completed. She tion administration records confirmed there was no neumococcal vaccine had Director of Nursing on		vaccinations given on the Vac Tracking Log. Education on the vaccination procedures will be the Executive Director for the Coordinator, Social Services I Staff Development Coordinator Director of Nursing by 3/23/17 D. The Executive Director and will bring the Pneumonia and Vaccination Tracking Log to the QAPI meeting for review times and random audits of all signed will be completed monthly the compliance.	ne e provided Admission Director, or and 7. d/or the D0 Flu ne monthly s 3 month ed consen	ON y s ts	
	staff to have reviewe administered the vac determined it was sti An interview with the at 4:48 PM revealed vaccine to be administreceiving the consenfurther stated if the valid expect for stated.						