DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>′</i>		CONSTRUCTION	COMF	E SURVEY PLETED
		345322	B. WING				C /05/2020
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	00	03/2020
	RELS OF HENDERSONV	IIIF		29	0 CLEAR CREEK ROAD		
				HE	ENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000		8.73, Emergency ID #VCT711.	F0	000			
	investigation survey v through 03/05/20. A t	ertification and complaint vas conducted 03/02/20 otal of 2 allegations were as substantiated. Event ID					
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-	(3)(8)	F 5	61			4/1/20
	promote and facilitate through support of re	right to and the facility must resident self-determination sident choice, including but is specified in paragraphs (f)					
	activities, schedules (waking times), health						
		ident has a right to make s of his or her life in the cant to the resident.					
	with members of the community activities I facility.	ident has a right to interact community and participate in both inside and outside the					
		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
Electroni	cally Signed						03/28/2020

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.

		D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345322	B. WING		C 03/05/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE LAUF	RELS OF HENDERSONV	LLE		290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	D.475
F 561	Continued From page	9 1	F 561		
	religious, and commu interfere with the right facility. This REQUIREMENT by: Based on record revi interviews, the facility scheduled for 2 of 3 r choices (Residents #6 The findings included 1. Resident #64 was a following a cerebral in Review of the quarter dated 02/21/20 indica cognitively intact and assistance with bed n and toileting, and limit hygiene. Resident #6 staff for bathing. Resi or exhibit any behavio The shower/bathing re Resident #64 was giv 02/19/20, and 02/27/2 went 12 days without 02/13/20 it was docur did not receive a show	tivities, including social, nity activities that do not is of other residents in the is not met as evidenced ew, resident and staff failed to provide showers as esidents reviewed for 64 and #62). dmitted on 07/06/17 farct. ly Minimum Data Set (MDS) ted Resident #64 was required extensive nobility, transfers, dressing ted assistance with personal 4 was totally dependent on dent #64 did not reject care ors. ecord for February 2020, en showers on 02/06/20, 20, indicating Resident #64 a shower. On 02/10/20 and nented that Resident #64 wer and on 02/17/20 there in to indicate if a shower had		The Laurels of Hendersonville request to have this submitted plan of correction stand as its written allegation plan of compliance. Our compliance date is 4/1/2020. Preparation and/or execution of this plat does not constitute admission to nor agreement with either existence of or scope of severity of the cited deficienci This plan is prepared and/or executed ensure compliance with regulatory requirements. F561 Self Determination The facility will continue to promote an facilitate resident self-determination through support of resident choice. Resident #62 and #64 shower schedul and preferences have been discussed individually and preferences document within their electronic task records. All residents in the facility have the abit to be affected. No negative outcome w identified relating to this observation. A residents in the facility will have shower schedules and preferences updated with	n an es. to d es ed lity as II r
	Resident #64 had file	ealed that on 02/19/20 d a grievance indicating he · in 2-3 weeks. Resident #64		their electronic record before 4/1/2020. Additionally, residents involved in resid council meeting were educated on	

Facility ID: 923081

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONS	TRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN			· · ·	MPLETED
							С
		345322	B. WING			0	3/05/2020
NAME OF PI	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF HENDERSONV	ILLE			EAR CREEK ROAD ERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 561	Continued From page	a 2	F 50	31			
1 001	was given a shower of		1.50		erent avenues to report grievances		
	grievance was consid				h regard to showers, care related		
	3				ues, or other general matters.		
	On 03/02/20 at 3:30 I	⊃M an interview was			, J		
		lent #64 who reported he did			e Assistant Director of Nursing has		
	not always get showe				ovided in-servicing on 3/13/2020 to		
		3 weeks without being			viding resident care with the ability	to	
	offered a shower.				cument activities of daily living to	h.,	
;	An interview was con	npleted with Nurse Aide (NA)			sure care is documented, specifical ower documentation/charting.	iy	
		1 PM who had documented			swer doeumentation/enarting.		
	that Resident #64 did			AC	QA monitoring tool will be created fo	r:	
		ted that Resident #64 did			cumentation/charting audits perform		
	not get his shower on	n 02/10/20 and it was			ekly for 12 weeks. Audits of shower		
	-	ey did not have enough staff			cumentation will reflect care has be	en	
		dicated that when staffing			vided for each guest as requested.	<i>.</i>	
		vere not always provided.			e Unit Manager will be responsible npleting these audits.	for	
		npleted with NA #2 on NA #2 had documented that		The	e facility will audit for 12 weeks, res	ulte	
	Resident #64 was no				be reported to DON with any varia		
		licated that Resident #64			dressed.	nee	
		his shower on that day					
		ot enough staff to provide		The	e DON will report the weekly finding	js to	
	them. NA #2 stated th	nat the shower team had		the	Administrator for review for the nex	kt 3	
		work a hall on that day. NA		mo	nths.		
	-	n the shower team was					
	-	she was sometimes able to			dit results will be reviewed for the n	ext	
	provide showers, but	not always.			nonths by the Quality Assurance mmittee to ensure compliance and/	or	
	An interview was con	npleted with NA #3 on			provide additional retraining if need		
		NA #3 was scheduled to					
		hall on 02/17/20. NA #3		Co	ntinued compliance will be monitore	ed	
	reported that she did	not give any showers on		thro	ough random audits of shower		
		er indicated that the NA who			cumentation and through the facilitie	es	
		d to give showers (shower		Qu	ality Assurance Program.		
		hall that day as there was					
	not enough staff. NA no one had been give	#3 indicated that it was likely					

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	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391				
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345322	B. WING			OMB NO. 0938-0391 ON (X3) DATE SURVEY COMPLETED C 03/05/2020 SS, CITY, STATE, ZIP CODE EEK ROAD VILLE, NC 28792 PROVIDER'S PLAN OF CORRECTION CCMPLETION COMPLETION C	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE LAU	RELS OF HENDERSONV	ILLE			90 CLEAR CREEK ROAD IENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION
F 561	Continued From page	3	F	561			
	Assistant Director of I reported that the facil had not been provide reported she was lool new system for show. The ADON stated that provided because the members. The ADON expectation that show scheduled. On 03/05/20 at 1:49 F interviewed who state come to her on 02/19 had a shower in a few grievance for him and shower on that same indicated that becaus facility was having tro been provided as sch reported the facility w model to correct the is expectation that show scheduled. 2. Resident #62 was 09/16/19 with multiple diabetes, chronic kidr failure, vascular deme disturbance, and anxi The quarterly Minimu 02/07/20 assessed R cognition. The MDS i required limited to ext all activities of daily limited to ext al	PM the Administrator was ed that Resident #64 had /20 and reported he had not v weeks. She then filed a I had staff give him a day. The Administrator e staffing was an area the uble with, showers had not eduled. The Administrator as working on a new staffing ssue and that it was her vers were provided as admitted to the facility on e diagnoses that included ney disease with heart entia without behavioral					

Facility ID: 923081

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	ECONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _				
		345322	B. WING				C 105/2020	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2020	
	RELS OF HENDERSONV			2	90 CLEAR CREEK ROAD			
	RELS OF HENDERSON			ŀ	HENDERSONVILLE, NC 28792			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 561	- 15	did not occur during the	F	561				
	The shower/bathing r revealed Resident #6 2 showers per week of was documented Resident 2 02/22/20 and 02/28/2 documentation Resid assistance on 02/04/2 02/14/20, 02/18/20, o #62 went 21 days with During an interview o Resident #62 shared receive 2 showers per received one. Resid month, she went 2 we when she mentioned would try to give her of During an interview o Nurse Aide (NA) #4 c to provide care to Resident 2 02/11/20 and 02/14/2 part of the shower tea work the hall as a NA able to provide her as scheduled shower, in the facility being shor when working short-s just to keep residents During an interview o #5 confirmed she was Resident #62 on 02/1 explained as a hall Na care needs of the residents	ecord for January 2020 2 was scheduled to receive on Tuesdays and Fridays. It sident received showers on 0; however, there was no ent #62 received bathing 20, 02/07/20, 02/11/20, r 2/25/20 indicating Resident hout a shower. n 03/02/20 at 9:21 AM she was supposed to r week but usually only ent #62 added just last seks without a shower and it to staff, they stated they one if they had time. n 03/03/20 at 9:21 PM onfirmed she was assigned sident #62 on 02/04/20, 0. NA #4 explained she was am but had been pulled to on those days and was not assigned residents with their cluding Resident #62, due to t-staffed. NA #4 added taffed, their main focus was						

Facility ID: 923081

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/02/2020 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345322	B. WING		_		C 05/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
	RELS OF HENDERSONVI			290 CLEAR CREEK ROAD	1		
	KELS OF HENDERSONVI	LLE		HENDERSONVILLE, NO	28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page showers. NA #5 adde aide was pulled to wo get provided to the re- had never provided R During an interview of #6 shared she was pa was assigned to the 2 showers on 02/07/20, NA #6 stated staffing most days, she was p to work the floor as a she was not pulled to were provided as sch supposed to documer medical record when refused. NA #6 review electronic bathing doo there was nothing doo was assigned to proviverbalized when she Manager would call h provided and usually nothing was documer not provided. NA #6 i was pulled from the s 02/18/20 and 02/25/2 due to the facility not not have the time to p residents with their sch During a joint interview the Assistant Director reported the facility wo being provided to resi staffing issues and wa a new system for sho	e 5 ed whenever the shower rk the floor, showers did not sidents. NA #5 reported she esident #62 with a shower. In 03/05/20 at 2:11 PM, NA art of the shower team and 200 Hall to provide resident 02/18/20, and 02/25/20. has been a challenge and ulled from the shower team NA. NA #6 shared when work the floor, showers eduled and she was in the resident's electronic the shower was provided or wed Resident #62's cumentation and confirmed cumented for the dates she ide showers. NA #6 forgot to document, the Unit er to ask if the shower was indicated it was likely she hower team on 02/07/20, 0 to work the hall as a NA having enough staff and did rovide her assigned theduled shower. W on 03/05/20 at 8:54 AM, of Nursing (ADON) as aware showers were not dents as scheduled due to as looking into implementing wering to correct the issue.	F 56				
	The ADON verbalized	l it was her expectation that e provided as scheduled.					

Facility ID: 923081

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345322	B. WING				C 05/2020
NAME OF PI	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
THE LAUF	RELS OF HENDERSONV	LLE			290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561 F 582 SS=B	During a joint interviet the Administrator state staffing challenges ar aides were often pulle NA and showers were as scheduled. The Ad- tried to make up the s and were working on correct the issue. The she was aware of res showers were not bei and stated she would stated she did not rec Administrator added i showers were provide Medicaid/Medicare C- CFR(s): 483.10(g)(17) \$483.10(g)(17) The fa (i) Inform each Medica writing, at the time of facility and when the the Medicaid of- (A) The items and ser nursing facility service for which the resident (B) Those other items facility offers and for v charged, and the amo-	w on 03/05/20 at 8:54 AM, ed the facility had faced ad as a result, the shower ed to the floor to work as a e not provided to residents dministrator explained they showers that were missed a new staffing model to e Administrator verbalized ident complaints that ng provided as scheduled believe Resident #62 if she seive a shower. The t was her expectation that ed as scheduled. overage/Liability Notice)(18)(i)-(v) acility must aid-eligible resident, in admission to the nursing resident becomes eligible for vices that are included in es under the State plan and may not be charged; and services that the which the resident may be ount of charges for those		561			4/1/20
	changes are made to specified in §483.10(g section. §483.10(g)(18) The fa	aid-eligible resident when the items and services g)(17)(i)(A) and (B) of this acility must inform each the time of admission, and					

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/02/202 FORM APPROVEI OMB NO. 0938-039		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345322	B. WING _		C 03/05/2020		
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP	CODE		
THE LAU	RELS OF HENDERSONV	ILLE		290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792	92		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE		
F 582	periodically during the available in the faciliti services, including ar covered under Medic facility's per diem rate (i) Where changes in and services covered Medicaid State plan, notice to residents of reasonably possible. (ii) Where changes a items and services the facility must inform the 60 days prior to imple (iii) If a resident dies transferred and does facility must refund to representative, or est deposit or charges al per diem rate, for the resided or reserved of facility, regardless of discharge notice requ (iv) The facility must resident representative the resident within 30 date of discharge from (v) The terms of an a behalf of an individual facility must not confit these regulations. This REQUIREMENT by: Based on record rev facility failed to provid (Centers for Medicare Skilled Nursing Facilit Notice) prior to disch	e resident's stay, of services y and of charges for those ny charges for services not are/ Medicaid or by the e. coverage are made to items I by Medicare and/or by the the facility must provide the change as soon as is re made to charges for other the facility offers, the re resident in writing at least ementation of the change. or is hospitalized or is not return to the facility, the the resident, resident tate, as applicable, any ready paid, less the facility's days the resident actually or retained a bed in the any minimum stay or uirements. refund to the resident or ve any and all refunds due 0 days from the resident's	F 5	The facility will provide each Medicaid/Medicare Cover eligible resident, in writing admission to the facility a resident becomes eligible eligibility for items or serv	rage/Liability g, at the time of nd when the e or changes		

Facility ID: 923081

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		MEDICAID SERVICES			OMB NO. 0938-
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SURVEY COMPLETED
			A. BUILDING	<u> </u>	с
		345322	B. WING		03/05/2020
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,00,2020
		() . -		290 CLEAR CREEK ROAD	
THE LAUF	RELS OF HENDERSONV			HENDERSONVILLE, NC 28792	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE
F 582	Continued From pag	e 8	F 58	2	
	beneficiary protection			include in the nursing facility serv	vices
	(Residents #31 and #			under Medicare and/or State plar	
		,		which the resident may not be ch	
	Findings included:			and those items and services that	t the
				facility offers and for which the re	
		admitted to the facility on		may be charged, and the amount	
	02/05/19.			charges for those services; and in	
	A review of the medie	cal record revealed a		each eligible resident when chan made to the items and services.	ges are
		of Medicare Non-Coverage		made to the items and services.	
		signed by Resident #31's		Resident #31 no longer resides ir	n the
		2/13/19 which indicated		facility. Resident #70 currently res	
	Medicare Part A cove	erage for skilled services		the facility without issue. Potentia	al
		19. Resident #31 remained		residents to be affected include:	
	-	e NOMNC was issued with		residents in which Medicare Part	
	Medicare Part A bene	efits remaining.		coverage for skilled services end	
				resident remains in the facility wit	
	A review of the medie	N was not provided to		Medicare Part A benefits remaining negative outcomes were identifie	
	Resident #31.	N was not provided to		to this observation.	urelating
	-	on 03/03/20 at 3:50 PM, the		The facility Business Office Mana	•
	Social Worker (SW)			Social Workers were in-serviced	
	· ·	ng the NOMNC to the		3/4/2020 by the Administrator on	
	-	ponsible Party (RP) once s Medicare Part A coverage		policy with regard to issuing SNF along with Medicare denials acco	
		as ending. The SW added		CMS guidelines. The Social Work	
		F ABN was also required		be responsible for issuing ABN ge	
		mained in the facility with		forward.	č
	Medicare Part A bene	efits remaining. The SW			
		e previous Business Office		The Administrator will audit all res	
		a system in place where the		who discharge Medicare Part A a	
		d the SNF ABN and she		remain in the facility weekly for the	
		however, the current BOM		weeks, and then randomly for the two months.	enext
		facility for a few months and a chance to work out a			
		responsible for providing the		Continued compliance will be mo	nitored
	-	otice. She confirmed the		through random audits of Medica	
		ovided to Resident #31 and		discharged patients and through	

Facility ID: 923081

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	-	ID HUMAN SERVICES				FORM	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	SURVEY
		345322	B. WING _	FORM APPROVED OMB NO. 0938-0391 TIPLE CONSTRUCTION NG MG C OBJ05/2020 STREET ADDRESS, CITY, STATE, ZIP CODE 290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792 X PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE			
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAURELS OF HENDERSONVILLE				29	00 CLEAR CREEK ROAD		
	KELS OF HENDERSONVI			H	ENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PROVIDERISUPPLIER/CLA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY 345322 B. WING C 345322 B. WING C 345322 STREET ADDRESS, CITY, STATE, ZIP CODE 200 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792 PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETED INT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETED INT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETED INT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETED INT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETED INT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETED Int of DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETED Int of DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETED Int of DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETED Int or DEFICIENCY ID F 582 facility's Quality Assurance Program. The Administrator will convey audit result to QA Committee for 3 months or until resolved and additional education/trainin	COMPLETION			
F 582	stated Resident #31's ended around the tim new BOM and the SM During an interview of Administrator reported Part A coverage ende new BOM started his The Administrator sta the SW would have p the NOMNC was issue system in place that in person for ensuring S The Administrator sta staff to issue the requi- and/or their RP when services were ending 2. Resident #70 was 09/08/19. A review of the medic CMS-10123 Notice of letter (NOMNC) was p family member on 10/ that Medicare Part A of would end on 10/18/1 in the facility after the Medicare Part A bene A review of the medic CMS-10055 SNF ABN Resident #70. During an interview of Social Worker (SW) in responsible for issuin- resident or their Resp	A Medicare Part A coverage e of the transition with the IF ABN got overlooked. In 03/03/20 at 4:17 PM, the d Resident #31's Medicare ed right around the time the employment with the facility. ted she would have thought rovided the SNF ABN when hed but realized they had no dentified a responsible SNF ABN were provided. ted she would expect for ired notices to residents Medicare Part A skilled admitted to the facility on al record revealed a f Medicare Non-Coverage provided to Resident #70's /16/19. The notice indicated coverage for skilled services 9. Resident #70 remained NOMNC was issued with fits remaining. al record revealed a N was not provided to n 03/03/20 at 3:50 PM, the holicated she was	F	582	The Administrator will convey audit res to QA Committee and ompliance will b monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for	e I	

If continuation sheet Page 10 of 30

CENTERS FOR MEDICARE & MEDICAI	N SERVICES D SERVICES			FORM	APPROVED 0.0938-0391
()	IDER/SUPPLIER/CLIA IFICATION NUMBER:		PLE CONSTRUCTION G		SURVEY LETED
	345322	B. WING			05/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAURELS OF HENDERSONVILLE			290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792		
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE I TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 F 582 Continued From page 10 for skilled services was ending she was aware a SNF ABN way when the resident remained in Medicare Part A benefits remained explained she and the previous Manager (BOM) had a system previous BOM issued the SNF issued the NOMNC; however, had only been at the facility for they had not yet had a chance process of who was responsible required SNF ABN notice. She SNF ABN was not provided to stated Resident #70's Medicar ended around the time of the tr new BOM and the SNF ABN get During an interview on 03/03/2 Administrator reported Resider Part A coverage ended right ar new BOM started his employm The Administrator stated she w the SW would have provided th the NOMNC was issued but re system in place that identified person for ensuring SNF ABN The Administrator stated she w staff to issue the required notic and/or their RP when Medicare services were ending. F 641 Accuracy of Assess The Assessment must accurate resident's status. This REQUIREMENT is not m by: 	as also required the facility with ining. The SW is Business Office in place where the ABN and she the current BOM to work out a le for providing the e confirmed the Resident #70 and e Part A coverage ransition with the ot overlooked. 0 at 4:17 PM, the fut #31's Medicare ound the time the tent with the facility. yould have thought the SNF ABN when alized they had no a responsible were provided. yould expect for the SNF ABN when alized they had no a responsible were provided. yould expect for the SNF ABN when alized they had no a responsible set or residents a Part A skilled	F 58			4/1/20

Event ID: VCT711

Facility ID: 923081

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OF DEFICIENCIES						
CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		PLETED
	345322	B. WING				С
	040022				03/	05/2020
COMPER OR SOLT EIER						
RELS OF HENDERSONVI	LLE					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG				(X5) COMPLETIO DATE
		F 64	41			
facility failed to accura Set (MDS) assessme	ately code Minimum Data nts in the areas of				9	
prognosis for 4 of 10	sampled residents			Resident #82, #44,and #69 had MDS corrections completed at the time of discovery. Resident #87 is no longer in		
Findings included:				the facility. No negative outcome was identified related to this observation.	1	
	•					
				potential to be affected. An audit of the	;	
the month of February	y 2020 indicated Resident			last 3 months relating to medications, discharge status, an hospice and		
				survey by the MDS Nurse. Any other	f	
revealed type 2 DM w	ith hyperglycemia was listed			alleged deficient proactive had a correction mad to the MDS by the MDS		
				Nurse. No negative observations were identified.		
assessment Minimum 02/25/20 indicated Re coded under Section	n Data Set (MDS) dated esident #82 had not been N 0350 as receiving insulin			in-serviced by the Clinical Resource Specialist on 3/16/2020 completing assessments that accurately reflect the		
AM, MDS Coordinato change MDS dated 0 Resident #82 due to s	r #1 stated the significant 2/25/20 was completed for skin concerns and weight			A QA monitoring toll will be utilized by t DON to ensure ongoing compliance. T DON will randomly audit MDS		
receiving insulin daily period and confirmed incorrectly. The MDS	during the 7-day look back Section N 0350 was coded Coordinator explained it			then randomly for 2 months to ensure MDS assessments are being complete that accurately reflect the resident's disposition. Variances will be corrected	ed Lat	
	SUMMARY STZ (EACH DEFICIENCY REGULATORY OR L Based on record revi facility failed to accura Set (MDS) assessme medications, discharg prognosis for 4 of 10 s (Resident # 82, #44, # Findings included: 1. Resident #82 was a 03/22/19 with multiple type 2 diabetes mellitu Review of medication the month of February #82 had received insu during the 7-day look Review of Resident # revealed type 2 DM w among other diagnose Review of the significa assessment Minimum 02/25/20 indicated Re coded under Section during the 7-day look During a phone interv AM, MDS Coordinato change MDS dated 02 Resident #82 due to s loss. She acknowledg receiving insulin daily period and confirmed incorrectly. The MDS	Resident #82 was admitted to the facility on 03/22/19 with multiple diagnoses that included type 2 diabetes mellitus (DM) with hyperglycemia. Review of Resident #82's electronic profile revealed type 2 DM with hyperglycemia was listed among other diagnoses. Review of the significant change in status assessment Minimum Data Set (MDS) dated 02/25/20 at 11:39 AM, MDS Coordinator #1 stated the significant change MDS dated 02/25/20 was completed for Resident #82 was admitted to the facility on 03/22/19 with multiple diagnoses that included type 2 diabetes mellitus (DM) with hyperglycemia. Review of medication administration record for the month of February 2020 indicated Resident #82 had received insulin injection daily for DM during the 7-day look back period. Review of Resident #82's electronic profile revealed type 2 DM with hyperglycemia was listed among other diagnoses. Review of the significant change in status assessment Minimum Data Set (MDS) dated 02/25/20 indicated Resident #82 had not been coded under Section N 0350 as receiving insulin during the 7-day look back period. During a phone interview on 03/02/20 at 11:39 AM, MDS Coordinator #1 stated the significant change MDS dated 02/25/20 was completed for Resident #82 was receiving insulin daily during the 7-day look back period.	ROVIDER OR SUPPLIER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 11 F 6 Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of medications, discharge status, hospice and prognosis for 4 of 10 sampled residents (Resident # 82, #44, #87, and #69). F 6 Findings included: 1. Resident #82 was admitted to the facility on 03/22/19 with multiple diagnoses that included type 2 diabetes mellitus (DM) with hyperglycemia. Review of medication administration record for the month of February 2020 indicated Resident #82 had received insulin injection daily for DM during the 7-day look back period. Review of Resident #82's electronic profile revealed type 2 DM with hyperglycemia was listed among other diagnoses. Review of the significant change in status assessment Minimum Data Set (MDS) dated 02/25/20 indicated Resident #82 had not been coded under Section N 0350 as receiving insulin during the 7-day look back period. During a phone interview on 03/02/20 at 11:39 AM, MDS Coordinator #1 stated the significant change MDS dated 02/25/20 was completed for Resident #82 due to skin concerns and weight loss. She acknowledged that Resident #82 was receiving insulin daily during the 7-day look back period and confirmed Section N 0350 was coded incorrectly. The MDS Coordinator explained it was an oversight and a modification would be	ROVIDER OR SUPPLIER S RELS OF HENDERSONVILLE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 11 F 641 Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of medications, discharge status, hospice and prognosis for 4 of 10 sampled residents (Resident #82, #44, #87, and #69). Findings included: 1. Resident #82 was admitted to the facility on 03/22/19 with multiple diagnoses that included type 2 diabetes mellitus (DM) with hyperglycemia. Review of medication administration record for the month of February 2020 indicated Resident #82 had received insulin injection daily for DM during the 7-day look back period. Review of the significant change in status assessment Minimum Data Set (MDS) dated 02/25/20 indicated Resident #82 had not been coded under Section N 0350 as receiving insulin during the 7-day look back period. During a phone interview on 03/02/20 at 11:39 AM, MDS Coordinator #1 stated the significant change MDS dated 02/25/20 was completed for Resident #82 due to skin concerns and weight loss. She acknowledged that Resident #82 was receiving insulin daily during the 7-day look back period and confirmed Section N 0350 was coded incorrectly. The MDS Coordinator explained it was an oversight and a modification would be	ROWDER OR SUPPLIER STREET ADDRESS, CITV. STATE, ZIP CODE RELS OF HENDERSONVILLE 29 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S FLAN OF CORRECTION (EACH OERCETTIVE ACTION SHOLLDS COOSS-REFERENCED TO TYPE ACTION SHOLLDS COOSS-REFERENCED TO TYPE ACTION SHOLLDS CONSS-REFERENCED TO TYPE ACTION SHOLLDS CONSS-REFERENCED TO TYPE ACTION SHOLLDS CONTINUE AT ACTION SHOLLDS CONTINUE AT ACTION SHOLLDS CONTINUE ACTION SHOLLSS CONTINUE ACTION SHOLLDS CONTINUE ACTION SHOLLSS CONTIN	345322 B. WING 033 ROWDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 230 CLEAR CREEK ROAD RELS OF HENDERSONVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRATE DEFICIENCY MIST BERCECEDE BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX PREFX PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRATE DEFICIENCY MIST BERCECEDE BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFX PROVIDER'S FLAN OF CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRATE DEFICIENCY Continued From page 11 F641 The facility will continue to complete assessments that accurately reflect the resident's status. F641 Findings included: ID (Resident #82, #44, #87, and #69). F641 The facility will continue to complete assessments that accurately reflect the resident's status. Resident #82, #44, and #69 had MDS corrections completed at the time of discovery. Resident #82, #44, and #69 had MDS corrections completed at the time of discovery. Resident #82, was admitted to the facility on 03/22/19 with multiple diagnoses that included type 2 diabetes mellitus (DM) with hyperglycemia. All current residents and to be MDS assessments completed within the last 3 months relating to medications, discharge status, an hospice and progrosis was concluded at the time of survey by the MDS Nurse. Any other resident diagnoses. Review of the significant the most of related the significant thange MDS datet 02/25/20 was completed for Resident #82 had not been

Facility ID: 923081

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0 (X3) DATE SU	RVEY
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLE	ED
		345322	B. WING		C 03/05	2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		2020
				290 CLEAR CREEK ROAD		
THE LAU	RELS OF HENDERSONV	ILLE		HENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETIO DATE
F 641	Continued From page	e 12	F 64	11		
	During an interview of Assistant Director of she was aware of the accuracy and felt it w turnover in MDS dep was her expectation be coded accurately. During an interview of Administrator stated required two full time handle the workload. turnover, MDS Coord alone in the past 6 m Coordinator working The Administrator att oversight due to care	on 03/05/20 at 10:43 AM, the Nursing (ADON) confirmed e issues identified with MDS as a result of recent staff artment. The DON stated it for all MDS assessments to on 03/05/20 at 1:25 PM, the the MDS department MDS Coordinators to However, due to staff linator #1 had been working onths with a part-time MDS for only 6 hours per week. ributed the incidents as an lessness. It was her DS assessment to be coded he clinical needs or		 Audit results will be report Administrator for the next concern will be reported to Assurance Committee du meetings. Continued compliance will through random audits of assessments and through Quality Assurance Progra The Administrator will con QA Committee and compl monitored by the QA Commonths or until resolved a education/training will be issues identified. 	3 months and o the Quality ring monthly II be monitored MDS o the facility's im. avey results to liance will be omittee for 3 and additional	
	08/14/17 with multiple	admitted to the facility on e diagnoses that included diabetes mellitus, anxiety,				
	the month of January #44 had received Eff antidepressant) even	n administration record for 2020 indicated Resident exor extended release (an y night at bed time for e 7-day look back period.				
		44's electronic profile was listed among other				
	Minimum Data Set (N	rly review assessment /IDS) dated 01/13/20 14 had not been coded				

Facility ID: 923081

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	
		345322	B. WING				05/2020
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF HENDERSONV	ILLE			90 CLEAR CREEK ROAD IENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	During an interview o MDS Coordinator #2 was coded incorrectly #44 was receiving an 7-day look back perio not the MDS Coordina MDS as she had beer weeks. She would co modification would be During an interview o Assistant Director of I she was aware of the accuracy and felt it wa turnover in MDS depa was her expectation f be coded accurately. During an interview o Administrator stated to required two full time handle the workload. turnover, MDS Coord alone in the past 6 mc Coordinator working f The Administrator attr oversight due to caref expectation for all MD accurately to reflect to conditions of the Resi 3. Resident #87 was a 01/21/20 with multiple acute bronchiolitis, ar	as receiving the 7-day look back period. In 03/03/20 at 1:03 PM, the confirmed Section N 0410 and indicated that Resident tidepressant daily in the d. She explained she was ator who completed this in working for less than 2 rrect the error and a e submitted. In 03/05/20 at 10:43 AM, the Nursing (ADON) confirmed issues identified with MDS as a result of recent staff artment. The DON stated it for all MDS assessments to In 03/05/20 at 1:25 PM, the he MDS department MDS Coordinators to However, due to staff inator #1 had been working poths with a part-time MDS for only 6 hours per week. ributed the incidents as an lessness. It was her DS assessment to be coded he clinical needs or ident.	F	541			
	Review of progress n	otes dated 01/31/20					

Facility ID: 923081

If continuation sheet Page 14 of 30

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 345322 B. WING 03/05/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 03/05/2020 THE LAURELS OF HENDERSONVILLE STREET ADDRESS, CITY, STATE, ZIP CODE 290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		-	ID HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
345322 9. WING	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMP	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE LAURELS OF HENDERSONVILLE IMAGE OF PROVIDER OF SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL RECOLL TORY OR LSC IDENTIFYING INFORMATION) Image: Department of Deficiencies (EACH DEFICIENCY NUST BE PRECIDED BY FULL RECOLL TORY OR LSC IDENTIFYING INFORMATION) Image: Department of Deficiencies (EACH DEFICIENCY NUST BE PRECIDED BY FULL Recoll to the provide at the precision of the precision			345322	B. WING				-
THE LAURELS OF HENDERSONVILLE HENDERSONVILLE, NC 28792 Image: Constraint of the proceed of the process of the proces of the process of the process of the process of the p	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE F 641 Continued From page 14 revealed Resident #87 was discharged home that day. F 641 F 641 Review of physician's orders dated 01/30/20 indicated Resident #87 was discharged home with home health provided at home. F 641 Review of post discharge plan of care dated 01/27/20 indicated Resident #87 ks discharge location would be independent living and discharge date would be on 01/30/20. Review of the discharge Minimum Data Set (MDS) dated 01/30/20 indicated Resident #87 had been coded under Section A 2100 for discharge status as discharged to acute hospital. During an interview on 03/03/20 at 2:03 PM, the Social Worker confirmed Resident #87 was discharge home on 01/30/20 as his rehab goals had been met. During an interview on 03/03/20 at 2:36 PM, the MDS Coordinator #2 confirmed Section A 2100 was coded incorrectly and indicated that Resident #87 was discharged home instead of acute	THE LAUF	RELS OF HENDERSONV	ILLE					
revealed Resident #87 was discharged home that day. Review of physician's orders dated 01/30/20 indicated Resident #87 was discharged home with home health provided at home. Review of post discharge plan of care dated 01/27/20 indicated Resident #87's discharge location would be independent living and discharge date would be on 01/30/20. Review of the discharge Minimum Data Set (MDS) dated 01/30/20 indicated Resident #87 had been coded under Section A 2100 for discharge status as discharged to acute hospital. During an interview on 03/03/20 at 2:03 PM, the Social Worker confirmed Resident #87 was discharge home on 01/30/20 as his rehab goals had been met. During an interview on 03/03/20 at 2:36 PM, the MDS Coordinator #2 confirmed Section A 2100 was coded incorrectly and indicated that Resident #87 was discharged home instead of acute	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
Coordinator who responsible to complete this MDS as she had been working for less than 2 weeks. She would correct the error and a modification would be submitted. During an interview on 03/05/20 at 10:43 AM, the Assistant Director of Nursing (ADON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of recent staff turnover in MDS department. The DON stated it was her expectation for all MDS assessments to be coded accurately.	F 641	revealed Resident #8 day. Review of physician's indicated Resident #8 with home health prov Review of post discha 01/27/20 indicated Re location would be indi- discharge date would Review of the dischar (MDS) dated 01/30/20 had been coded under discharge status as d During an interview o Social Worker confirm discharge home on 0 had been met. During an interview o MDS Coordinator #2 was coded incorrectly #87 was discharged H hospital. She explaine Coordinator who resp MDS as she had beet weeks. She would co modification would be During an interview o Assistant Director of I she was aware of the accuracy and felt it wa turnover in MDS depa was her expectation f	7 was discharged home that orders dated 01/30/20 7 was discharged home vided at home. arge plan of care dated esident #87's discharge ependent living and be on 01/30/20. The Minimum Data Set 0 indicated Resident #87 er Section A 2100 for ischarged to acute hospital. In 03/03/20 at 2:03 PM, the ned Resident #87 was 1/30/20 as his rehab goals In 03/03/20 at 2:36 PM, the confirmed Section A 2100 y and indicated that Resident home instead of acute ed she was not the MDS ionsible to complete this in working for less than 2 rrect the error and a e submitted. In 03/05/20 at 10:43 AM, the Nursing (ADON) confirmed issues identified with MDS as a result of recent staff artment. The DON stated it	F	541			

Facility ID: 923081

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	ECONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			LETED
		345322	B. WING				C 05/2020
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 05/	03/2020
	RELS OF HENDERSONV	ILLE			290 CLEAR CREEK ROAD		
_				ŀ	IENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	9 15	F	641			
	Administrator stated t required two full time handle the workload. turnover, MDS Coord alone in the past 6 m Coordinator working f The Administrator attr oversight due to caref expectation for all MD accurately to reflect th conditions of the Resi 4. Resident #69 was a 06/09/11 with multiple atrial fibrosis, cirrhosi malnutrition, anxiety, Review of physician's revealed an order of h loss and global geriat Review of the Hospic Resident #69 was sta services for end of life of 02/06/20. Review of the signific assessment Minimum 02/19/20 indicated un Prognosis, Resident # condition or chronic d life expectancy of less under Section O for S	MDS Coordinators to However, due to staff inator #1 had been working onths with a part-time MDS for only 6 hours per week. ributed the incidents as an lessness. It was her DS assessment to be coded he clinical needs or ident. admitted to the facility on a diagnoses that included s, diabetes mellitus, and depression. a order dated 02/05/20 hospice consult for weight ric decline was in place. e progress notes indicated ant change in status n Data Set (MDS) dated ider Section J-1400 for #69 was not coded with a lisease that may result in a s than 6 months. In addition, Special Treatments and coded to indicate Resident					
	During an interview o	n 02/25/20 at 2:57 PM, the					

Facility ID: 923081

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/02/2020 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345322	B. WING				C / 05/2020
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF HENDERSONV	ILLE			290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	ordered for hospice c Resident #69 was un 02/06/20. During a phone interv AM, the MDS Coordin significant MDS dated for Resident #69 due weight loss. She ackr had been under hosp confirmed Section J 1 coded incorrectly. The explained it was an or would be submitted. During an interview of Assistant Director of I she was aware of the accuracy and felt it we turnover in MDS depa was her expectation f be coded accurately. During an interview of Administrator stated to required two full time handle the workload. turnover, MDS Coord alone in the past 6 mo Coordinator working f The Administrator attr oversight due to caref expectation for all ME accurately to reflect th	hed that the physician had onsult on 02/05/20 and der hospice care by fiew on 03/04/20 at 10:11 hator #1 stated the d 02/19/20 was completed to hospice admission and howledged that Resident #69 ice care since 02/06/20 and 400 and Section O were e MDS Coordinator versight and a modification in 03/05/20 at 10:43 AM, the Nursing (ADON) confirmed issues identified with MDS as a result of recent staff artment. The DON stated it for all MDS assessments to in 03/05/20 at 1:25 PM, the he MDS department MDS Coordinators to However, due to staff inator #1 had been working poths with a part-time MDS for only 6 hours per week. ributed the incidents as an lessness. It was her DS assessment to be coded he clinical needs or	F	641			
F 657 SS=D	conditions of the Resi Care Plan Timing and CFR(s): 483.21(b)(2)	Revision	F	657	,		4/1/20

Facility ID: 923081

If continuation sheet Page 17 of 30

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _				
		345322	B. WING			C 03/05/2020		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
THE LAUF		ILLE			90 CLEAR CREEK ROAD			
				F	IENDERSONVILLE, NC 28792			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page	9 17	F	657				
	§483.21(b) Comprehe	ensive Care Plans						
	§483.21(b)(2) A comp	prehensive care plan must						
	be- (i) Developed within 7	days after completion of						
	the comprehensive as	ssessment.						
	(ii) Prepared by an int includes but is not lim	terdisciplinary team, that						
	(A) The attending phy							
		e with responsibility for the						
	resident. (C) A nurse aide with	responsibility for the						
	resident.	responsibility for the						
		and nutrition services staff.						
		ticable, the participation of esident's representative(s).						
		be included in a resident's						
		participation of the resident						
	not practicable for the	resentative is determined e development of the						
	resident's care plan.							
		staff or professionals in ined by the resident's needs						
	or as requested by the	5						
	(iii)Reviewed and revi	ised by the interdisciplinary						
	team after each assest comprehensive and q	ssment, including both the						
	assessments.							
		is not met as evidenced						
	by: Based on observation	ns, record review, staff and			The facility will continue to ensure care	ė		
		he facility failed to update a			plans are updated timely.	-		
		our sampled residents in the			Decident #11 and #00 had as marking			
	areas of discharge pla #11 and 60).	an and nutrition (Residents			Resident #11 and #60 had corrections made to their individual care plans with			
					regard to discharge plans and nutrition			
	The findings include:				the time of discovery.			
	1. Resident #11 was a	admitted on 12/19/19 for			All residents have the ability to be			

Event ID: VCT711

Facility ID: 923081

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	IPLETED
						С
		345322	B. WING		03	8/05/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF HENDERSONV	/ILLE		290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE
F 657	Continued From pag	e 18	F 65	77		
		istaining a hip fracture.	1 00	affected. Beginning 3/10/2020 all	resident	
		a np naotaro.		care plans will transition to an ele		
		lan dated 12/25/19 revealed		update process and will be acces	sed	
		ent #11 to return home		electronically, paper care cards w		
		ncluded: provision of training		eliminated. An audit of each indiv		
		iving (ADL) that had to be o discharge, home health		care plan will occur as each care transferred to the electronic mode		
		set up prior to discharge, and		Transfer of all records will be con		
		m the physician was to be		later than 4/1/2020.		
				The MDS Coordinator and Assist		
		um Data Set (MDS) on		in-serviced by the Clinical Resour		
		26/19 indicated Resident		Specialist 3/16/2020 on the electro		
	#11 was moderately	ssistance with bed mobility,		care plan processes, updates, an accessibility.	a	
	transfers, dressing, to	-		accessionity.		
		11 was receiving physical and		A QA monitoring tool will be utilize	ed to	
		and expected to discharge		ensure ongoing compliance by th		
	to the community.			The DON will randomly audit care	•	
				weekly for 4 weeks, and then ran	-	
		d 2/10/20 by the Nurse		2 months to ensure that care plan	าร	
		cated that Resident #11 had me and the NP did not		accurately reflect the resident's preferences, needs, and/or required	omente	
		was safe for discharge		Variances will be corrected at the		
		hat Resident #11 still needed		audit and additional education pro		
	assistance with ADL.			when indicated.		
	An interview was cor	npleted on 03/02/20 at 12:05		Audit results will be reported to the	e	
		1 during which Resident #11		Administrator for the next 3 mont		
	-	dy to go home and did not		concerns will be reported to the C	-	
	-	facility would not let him do		Assurance Committee during mo	nthly	
	SO.			meetings.		
	On 03/04/20 at 9:28	AM an interview was		Continued compliance will be mo	nitored	
		nerapy director who indicated		through random care plan audits	and	
		physically impaired enough		through the facility's Quality Assu	rance	
		nent was unsafe and further		Program.		
	stated that	able to each clean parform			ulte to	
	Resident #11 was un	able to cook, clean, perform		The Administrator will convey res	นแร เป	1

Facility ID: 923081

If continuation sheet Page 19 of 30

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/02/2020 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345322	B. WING				C 05/2020
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF HENDERSONV	ILLE					
				н	ENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	19	F	657			
		age his medications alone.		501	QA Committee and compliance will be		
					monitored by the QA Committee for 3		
	In an interview with th	ne NP on 03/05/20 at 2:11			months or until resolved and additional		
		at Resident #11 had not			education/training will be provided for a	any	
		be able to discharge home h cognitive and physical			issues identified.		
		indicated his new plan was					
	-	y and this had been the new					
	plan for weeks.	,					
	An interview was com	pleted with the Social					
		4/20 at 11:29 AM. The SW					
		sion regarding changing his					
	- ·	d around 01/22/20 when his ation had ended. The SW					
	-	e the Physician and NP					
		nd felt it was not safe for					
	Resident #11 to disch	arge home alone. The SW					
		nt #11 of the decision at that					
		that it was her responsibility					
		an to reflect the change in					
	because she had not	e had not done so yet thought about it					
		thought about it.					
	On 03/05/20 at 01:29	PM an interview was held					
		ector of Nursing (ADON)					
		esident #11 required more					
		could be provided at home					
	The ADON reported t	was to remain in the facility.					
	-	have been reflected in the					
	care plan in real time.						
	An interview was com	pleted with the					
	Administrator on 03/0	•					
		er expectation that care					
	plans were to be upda	ated as changes occurred.					
	2. Resident #60 was a	admitted on 1/30/20 for					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345322	B. WING				C 105/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE LAU	RELS OF HENDERSONV	ILLE			90 CLEAR CREEK ROAD IENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	aftercare following ga Additional diagnoses behavioral disturbance Review of his admiss 02/10/20 revealed Re cognitively impaired a eating. Resident #60 experienced weight lo Review of the medica plan dated 02/29/20 v was at risk for nutritio related to a mechanic thick liquids, impaired weight loss. Intervent for all meals, assistant indicated. On 03/03/20 at 8:18 A observed lying in bed breakfast tray was on of the meal had been On 03/04/20 at 08:12 observed in his room his meal had been co sitting up in his bed fil On 03/05/20 at 8:45 A observed eating his b was eating independe a good position to eat In an interview on 03/ Nursing Aide (NA) #1 Resident #60 ate in h #1 stated that staff wo	strointestinal surgery. included dementia without e. ion MDS assessment dated esident #60 was severely and required supervision with was coded as having oss. If record revealed a care which indicated Resident #60 nal and/or dehydration risk cally altered diet with honey I cognition and his history of ions included: dining room ace for completion as AM resident #60 was with his eyes closed, his the bedside table and none consumed. AM Resident #60 was with his meal tray. None of nsumed, Resident #60 was dgeting with a sugar packet. AM resident #60 was reakfast in his room. He ently, sitting up in his bed, in t.	F	657			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345322	B. WING				05/2020
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
THE LAU	RELS OF HENDERSONV	ILLE			90 CLEAR CREEK ROAD IENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	did not know that Res eat his meals in the d she could find that inf sheet used to inform a needs and assistance care) in his closet. An interview was held with NA #2 who states majority of his meals that she would somet go eat in the dining ro in his room and would dining room. NA #2 w #60's care plan indica in the dining room be was supposed to refle Resident #60 preferrer room. An interview was com Assistant on 03/04/20 that she and the MDS for managing the care to date. The MDS Ass care plan was not bei to let her know so it c An observation was m Resident #60's closet 03/04/20 at 11:40 AM #60's preference was room. The care card w	sident #60 had a care plan to ining room but reported that formation on the care card (a staff member of resident e level required for ADL d on 03/04/20 at 11:49 AM d that Resident #60 ate the in his room. NA #2 reported imes try to encourage him to bom, but he preferred to eat d often decline to go to the ras not aware that Resident ated he was to eat his meals cause the care card (which ect the care plan) indicated ed to eat his meals in his hpleted with the MDS 0 at 11:36 AM who reported 5 Director were responsible e plans and keeping them up sistant reported that if the ng followed staff would need ould be updated. hade of the care card in t with the MDS Assistant on which indicated Resident t to eat his meals in his was updated on 02/07/20. MDS Assistant was 20 at 11:40 AM who s a discrepancy as the care or reflect the care plan. The	F	657			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/02/2020 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		345322	B. WING		_		C 05/2020
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE LAUR	RELS OF HENDERSONVI	LLE		90 CLEAR CREEK ROAD IENDERSONVILLE, NC	28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657 F 725 SS=E	and care cards up to a On 03/05/20 at 01:29 with the Assistant Dire who indicated that Re meals in his room. Th care plan should have An interview was com Administrator on 03/0 indicated that Resider meals in his room and been updated. Sufficient Nursing Sta CFR(s): 483.35(a)(1)(§483.35(a) Sufficient The facility must have the appropriate compo- provide nursing and re resident safety and at practicable physical, r well-being of each res resident assessments and considering the n diagnoses of the facili accordance with the fa at §483.35(a)(1) The fac by sufficient numbers types of personnel on	staff to keep the care plans date. PM an interview was held ector of Nursing (ADON) sident #60 generally ate his e ADON stated that the e been updated. upleted with the 5/20 at 1:49 PM who nt #60 preferred to eat his d his care plan should have ff 2) Staff. sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care	F 657				4/1/20
	this section, licensed	ed under paragraph (e) of nurses; and connel, including but not					

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	MENT OF HEALTH AN S FOR MEDICARE & I				FORM): 04/02/2020 1 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345322	B. WING			C 05/2020
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
			29	90 CLEAR CREEK ROAD		
	RELS OF HENDERSONVI	LLE	н	ENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From page limited to nurse aides		F 725			
	 §483.35(a)(2) Except paragraph (e) of this is designate a licensed in nurse on each tour of This REQUIREMENT by: Based on record reviainterviews, the facility nursing staff to ensure showers for 2 of 3 res (Residents #62 and # Findings included: This tag is cross-referer F-561: Based on recoor interviews, the facility scheduled for 2 of 3 res choices (Resident #62 During an interview of Nurse #1 stated that so December 2019 they "more often than not." night she worked, res they did not receive the she had noticed resid frequently about staff call lights and having to be provided. Nurse 	when waived under section, the facility must nurse to serve as a charge duty. is not met as evidenced ews and resident and staff failed to maintain sufficient e residents received idents reviewed for choices 64). enced to: rd review, resident and staff failed to provide showers as esidents reviewed for 2 and #64).		Cross referenced to tag F561. The fa will maintain sufficient nursing staff wi the appropriate competencies and ski sets to provide nursing and related services to patients. Resident #62 and #64 shower schedules/preferences have been discussed individually and preference documented within the electronic task record. All residents in the facility have potential to be affected. No negative outcome was identified relating to this observation. The facility has provided in-servicing t staff on 3/13/2020 giving resident care with the ability to document activities of daily living to ensure care is document specifically shower documentation/charting. A QA monitoring tool will be created for Documentation/charting audits perform weekly for 12 weeks. Audits of showe documentation will reflect care has be	th II s e the o e of ted, or: ned r	
	and added when work to focus on meeting th	ting short-staffed, staff had ne basic care needs of the n, Nurse #1 reported staff e frequent		provided for each guest as requested Additionally, a staff monitoring tool wil created as a tracking tool for nursing department staffing ratios and used as indicator of insufficient staffing levels.	l be s an	

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			· ,	PLE CONSTRUCTION	(X3) DATE	OMB NO. 0938-03 (X3) DATE SURVEY	
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		PLETED		
		345322	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	040022		STREET ADDRESS, CITY, STATE, ZIP		/05/2020	
				290 CLEAR CREEK ROAD			
THE LAU	RELS OF HENDERSONV	/ILLE		HENDERSONVILLE, NC 28792	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE	
F 725	Continued From page	e 24	F 72	25			
 F 725 Continued From page 24 wandering behaviors and stated, "we usually have to let the residents wear themselves ou prior to assisting them to bed. Nurse #1 shat she tried to assist the Nurse Aides (NAs) as a as she could, which often put her behind on completing the medication pass. Nurse #1 reported that despite the Administration's effort to fill the open positions, staffing had not gott any better because the new employees they hired didn't stay. During an interview on 03/03/20 at 9:00 PM Nurse #2 was unable to recall the specific da but confirmed there was a period of time whe showers were not provided to the residents as scheduled due to the facility being short-staff Nurse #2 explained around tax time the facilit usually had a staffing shortage due to staff turnover and recently the facility offered NAs incentive bonuses to work extra shifts. During an interview on 03/04/20 at 9:44 AM, Rehab Director (RD) confirmed when the fac 		and stated, "we usually just ints wear themselves out" in to bed. Nurse #1 shared a Nurse Aides (NAs) as much often put her behind on cation pass. Nurse #1 the Administration's efforts ons, staffing had not gotten he new employees they had on 03/03/20 at 9:00 PM a to recall the specific dates was a period of time when ovided to the residents as a facility being short-staffed. around tax time the facility g shortage due to staff of the facility offered NAs work extra shifts.		 DON will oversee weekly and report results to the A each month for 3 months Administrator will oversee tool four times a week for weeks. Continued compliance wi through random documer audits, the daily staff mor facility's Quality Assurance The Administrator will cor QA Committee and comp monitored by the QA Con months or until resolved a education/training will be issues identified. 	Administrator . The e staff monitoring the next 12 Il be monitored ntation/charting nitor, and the ce Committee. nvey results to liance will be nmittee for 3 and additional		
	in to assist residents, case load, with gettin not on a consistent b recent occasions, ap November 2019 and 2020, when RS had a showers because the The RD explained re the facility staffing sc showers and only as schedule allowed. During an interview of Nurse Aide (NA) #6 r	who were not on therapy og showers but stated it was asis. The RD recalled 2 proximately 2 to 3 days in one weekend in February assisted with resident a facility was short-staffed. hab staff were not placed on hedule to provide resident sisted as their therapy on 03/04/20 at 11:15 AM, revealed they had worked oproximately December					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/02/2020 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345322	B. WING				C 6/ 05/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF HENDERSONV	LLE			290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	provide residents with twice a week. NA #6 wasn't the same as a give the resident "a gu was not always possi During an interview of Nurse #3 shared the f NAs since approxima #3 explained when we shower aides were pur resident care and stat residents with their so During an interview of #7 shared that for the regularly pulled from f floor due to staffing sh when short-staffed, th care with the focus or clean and dry. NA #7 effort to give a residen needed but when sho always able to be pro During an interview of #8 revealed staffing h shower aides were of which left no one avai showers. NA #8 adde care and was never in showers when there w aide for the hall. During an interview of Corporate Nurse Con facility had identified t	staff had not been able to a their scheduled showers added that even though it shower, she tried to at least bod bed bath" but even that ble when short-staffed. In 03/04/20 at 11:18 AM, facility had been short of tely December 2019. Nurse orking short-staffed, the illed to the floor to provide ff were not able to provide theduled showers. In 03/05/20 at 2:01 PM, NA past few months, she was the shower team to work the hortage. NA #7 explained hey had to prioritize resident in keeping the residents i stated she made every ht their shower when rt-staffed, showers weren't	F	728			

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		MEDICAID SERVICES	(X2) MULT	IPLE COM	NSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY			
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,			· · ·	COMPLETED		
							С		
		345322	B. WING			0;	8/05/2020		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
THE LAU	RELS OF HENDERSONV	ILLE			LEAR CREEK ROAD DERSONVILLE, NC 28792				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SH			IOULD BE COMPLETIC		
F 725	Continued From page	a 26	F7	725					
1725				25					
		lained members of the I voiced concerns they were							
		owers as scheduled and in							
	an effort to address the issue, the facility had paid								
	for staff to work extra hours to help provide								
		ne CNC added they had not							
		place to address showers							
	because they left the	issue was improving.							
	During a ioint intervie	w on 03/05/20 at 8:54 AM,							
	the Assistant Director of Nursing (ADON)								
	explained based on the current resident census								
		e preferred NA minimums per							
) AM to 7:00 PM, 6 NAs 7:00							
		s 3:00 PM to 11:00 PM, 4 0 AM, and 3 shower aides							
		Monday through Friday							
		ifficient to meet the residents							
		were no call-outs. The							
		e to the staffing challenges							
		it was difficult to meet their							
		She was aware residents							
		eir showers as scheduled doing all they could to							
		have had difficulty finding							
		ositions. She added staff							
		extra hours and when the							
		ulled to work the floor, they							
		showers that were missed							
		ntly did not have a system in nts who did not receive their							
	· ·	The ADON stated at first they							
		taff would fix the issue but it							
	had not helped as mu	uch as they had hoped and							
	the system was still b	proken.							
	During a joint intervie	w on 03/05/20 at 8:54 AM,							
	the Administrator con	firmed the facility faced a							
	staffing challenge and	d stated their recruitment							

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/02/2020 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345322	B. WING				C 05/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
THE LAUF	RELS OF HENDERSONVI	LLE		290 CLEAR CREEK ROAD HENDERSONVILLE, NC	28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page	27	F 72	5			
	process remained ong effort to attract more a job advertisements por sessions a local comm graduates, sponsored Chamber of Commerce bonuses. In addition, Aides to attend a NAA community college, of class to select NAs, of current staff, and incre- stated despite their be hard time finding NAs The Administrator star new staffing model the Aides who would also redistribute the work I reduce the number of alleviate the shortage QAPI/QAA Improvem CFR(s): 483.75(g)(2)(§483.75(g) Quality as §483.75(g)(2) The qual assurance committee (ii) Develop and imple action to correct ident This REQUIREMENT by: Based on staff intervit the Facility's Quality A Committee (QAA) fail procedures and monit committee put into pla annual recertification recited deficiency in the	going. She explained in an applicants, they had ongoing osted on Indeed, attended munity college to recruit new I hiring events at the ce, and offered sign-on they had paid for Hospitality certification course at a local ffered a Med Aide training ffered incentive bonuses to eased the wage scale. She east efforts, they still had a to fill the open positions. ted they were working on a at would utilize more Med work as NAs in an effort to oad which they felt would open positions needed and of staff. ent Activities iii) sessment and assurance. ality assessment and	F 86		inue to ensure that and Assurance at least quarterly to respect to which and assurance		4/1/20

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
					С			
		345322	B. WING			03/05/2020		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, 2	ZIP CODE			
THE LAURELS OF HENDERSONVILLE				290 CLEAR CREEK ROAD				
				HENDERSONVILLE, NC 287	'92			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE		
F 867	Continued From page	e 28	F	367				
	 again on the annual recertification survey on 03/05/20. This continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA programs. Findings included: This tag is cross referenced to: F 641-Accuracy of Assessments: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Sets (MDS) in the areas of medications, discharge status, hospice and prognosis for 4 of 10 residents reviewed for resident assessments, choices, closed records, and unnecessary medications (Resident # 82, #44, #87, and #69). During the recertification survey on 04/18/19 the facility was cited for F 641 for failure to accurately code the MDS for antipsychotic use in 1 of 5 residents reviewed for unnecessary medications. On 03/05/20 at 2:41 PM an interview was 			 and implements appropriation to correct identified deficiencies. The facility will continue assessments accurateling patient's medications, or hospice and prognosis, unnecessary medication anti-psychotic use. All effective corrected at the time of re-submitted as requires. The MDS Coordinator at in-serviced by the Clinic Specialist on 3/16/2020 assessments that accur resident's disposition. The facilities quality assessive of the serviced by the manager/Regional Ope procedures for develop implementing appropriation correct identified quality assessments. 	e to code MDS y to reflect a discharge status, , choices, ns, and errors were discovery and ed. and Assistant were cal Resource) completing rately reflect the surance committee e Regional QA erator on the ing and ate plans of action ality concerns.			
	indicated the MDS de been understaffed for remaining employee			cause of the identified of identifying, implementir the corrective action pla when an action plan ma revised. A QA monitoring tool wi	ng, and monitoring an and recognizing ay need to be			
	Coordinator with MDS	S assessments.		ensure ongoing complia The DON will randomly assessments weekly fo then randomly for 2 mo MDS assessments are that accurately reflect t	ance by the DON. audit MDS or 4 weeks, and onths to ensure that being completed			

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		ND HUMAN SERVICES				RM APPROVE
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED	
		345322	B. WING		0	C 3/05/2020
NAME OF PROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
		<i></i>		290 CLEAR CREEK ROAD		
THE LAURELS OF HENDERSONVILLE				HENDERSONVILLE, NC 28792		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ION SHOULD BE COMPLET THE APPROPRIATE DATE		
F 867	Continued From pag	je 29	F 8	 disposition. Variances will b the time of audit and addition provided when indicated. Audit results will be reported Administrator weekly for the months and concerns will be the Quality Assurance Commonthly meeting. A QA monitoring tool will be ensure ongoing compliance Regional QA Manager/Desi Regional QA Manager/Reg will attend the facility quality meeting monthly for two mon committee is developing an implementing appropriate p to correct quality concerns. be corrected and/or addition provided when indicated. The Administrator will convert QA Committee and continue will be monitored through the Quality Assurance Committee 	anal education d to the e next 3 e reported to mittee during utilized to by the gnee. The ional operator v assurance onths to ensure d lans of action Variances will hal education ey results to ed compliance he facility's	

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