STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING ______ B. WING ______	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	**1870 PISGAH DRIVE HENDERSONVILLE, NC 28791**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 06/19/24 through 06/21/24. Event ID#2T2S11. The following intakes were investigated NC00214950, NC00215352, NC00215374, NC00214752, and NC00215840. One (1) of the 15 allegations resulted in deficiency.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Physician interviews the facility failed to provide incontinence care in a safe manner for 1 of 3 residents reviewed for accidents (Resident #3). Findings included: Resident #3 was admitted to the facility 07/01/09 with diagnoses including stroke, hemiplegia (paralysis of one side of the body), repeated falls, and aphasia (a language disorder that affects a person's ability to communicate). Review of Resident #3's Physician orders revealed an order dated 05/03/22 for clopidogrel (an anti-platelet medication) 75 milligrams (mg) once a day for cerebral infarction (stroke) due to	F 689	Criteria 1 Resident #3 no longer resides in the facility. Criteria 2 All residents receiving assistance with peri care in bed are at risk for the alleged deficient practice. On July 8, 2024, an observation audit was completed by the Director of Nursing (DON) of all certified nursing assistants to determine if they could safely reposition a resident during peri care while in bed. Any concerns were addressed during the audit. Criteria 3	7/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/10/2024

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.

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F 689	Continued From page 1 unspecified occlusion of cerebral (brain) artery. The quarterly Minimum Data Set (MDS) assessment dated 01/24/24 revealed Resident #3 was moderately cognitively impaired, required partial to moderate assistance with rolling from side to side in bed, had impaired range of motion on one side of his upper and lower extremities, and was always incontinent of bowel and bladder. A telephone interview with Nurse Aide (NA) #1 on 06/19/24 at 3:10 PM revealed she was caring for Resident #3 when he fell out of bed the morning of 03/27/24. She stated she provided incontinence care for Resident #3 and was changing his bottom sheet when he fell out of bed. NA #1 explained she used the bed pad to turn Resident #3 away from her so she could place the clean bed sheet underneath him and he was using his unaffected arm to hold onto a dresser beside his bed. NA #1 stated Resident #3 let go of the dresser and fell face first onto the floor. She stated Resident #3 hit his head on the dresser as he fell and began bleeding from his head. NA #1 stated she immediately notified Resident #3's nurse of his fall and the nurse assessed him right away. She stated after Resident #3's nurse assessed him; she and the nurse assisted him back to bed. NA #3 stated she had only been employed at the facility for a couple of months at the time of Resident #3's fall and she had been trained by other NAs that he only required one person assist for incontinence care and linen changes. She stated she had been trained by facility staff to roll him away from her when providing care, even with no side rails or another staff member present to assist with care.	F 689	On or before July 8, 2024, the DON/designee will complete education and a clinical skills competency with all certified nursing assistants on the proper way to reposition a resident during peri care while in bed. The education includes review of the necessary steps required to ensure safe turning and use of assistive devices as applicable for a resident. Newly hired certified nursing assistants and those contracted through agencies will be educated and audited upon hire or prior to accepting a shift on the clinical skills and competency for repositioning a resident during peri care while in bed. Criteria 4 The Director of Nursing or designee will audit 5 certified nursing assistants a week for clinical competency on repositioning a resident during peri care while in bed for 8 weeks. The results of the audits will be brought to the monthly Quality Assurance Process Improvement Committee for review and recommendations will be made as the committee determines. The Administrator is responsible for implementing corrective action. Date of compliance is July 9, 2024	

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F 689	Continued From page 2	F 689		

A nurse's note written by Nurse #3 and dated 03/27/24 at 5:34 AM is as follows: "During rounds resident was turned and repositioned for care and fell out of the bed with 'certified nursing assistant' (CNA) present. Resident has a bruise on the left side of his head above the eyebrow, skin tear on the left knee, left elbow, second and third knuckle on the right hand. No present complaints of pain, no signs indicating resident is in discomfort. Resident was observed on his back when this writer entered the room. Vitals collected. Lacerations cleaned and dressed."

Nurse #3 was unavailable for interview during the survey.

Hospital records dated 03/27/24 documented Resident #3 was seen in the Emergency Department (ED) for a fall, facial laceration, and contusion of face at 10:21 AM. The note documented Resident #3 had bruising around his left eye, a laceration above his left eyebrow, and a skin tear to the left elbow and knee. A CT scan (detailed x-ray) dated 3/27/24 documented Resident #3 had no cervical spine (neck) fractures (broken bones), no facial fractures, and no intracranial (inside the skull) abnormality, but had a left forehead hematoma (bruise) with laceration. The note documented Resident #3's facial laceration did not require sutures (stitches) and was closed with tissue adhesive. The note documented Resident #3 was stable and was discharged back to the facility on 03/27/24 at 2:43 PM.

An interview with the Director of Nursing (DON) on 06/20/24 at 3:38 PM revealed all falls were discussed in the morning meeting. She stated Resident #3's fall on 03/27/24 was discussed in

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F 689	Continued From page 3 the morning meeting and Physical Therapy (PT) was going to evaluate him, his mattress was changed to a bolster mattress (a mattress with built-in bolsters that define the edges of the bed and helps prevent falls), and a halo bed rail (small, round upper handrail to aid with bed mobility) was added to his bed. The DON stated residents with hemiplegia should be turned toward staff when providing care and she educated NA #3 with that information via telephone. In a follow-up telephone interview with NA #3 on 06/19/24 she confirmed she received education on 03/27/24 by the DON to turn Resident #3 toward her in the future when providing his care due to hemiplegia. A telephone interview with Physician #1 on 06/20/24 at 10:32 AM revealed he was asked to assess Resident #3 after his fall the morning of 03/27/24. Physician #1 stated that he gave orders to send Resident #3 to the hospital for evaluation because when he assessed Resident #3, he was moaning, and he felt the laceration above his eyebrow required more than adhesive tape strips to allow the wound to heal. He stated he did not feel the delay between the time Resident #3 fell and the time he was sent to the hospital on 03/27/24 caused Resident #3 any harm. An interview with the Administrator on 06/21/24 at 10:31 AM revealed she felt Resident #3 had not been eating well prior to his fall and that probably caused him to be weaker and his fall was just an unforeseen accident.	F 689		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345312	A. BUILDING: ______ B. WING ______	**6/21/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	**1870 PISGAH DRIVE HENDERSONVILLE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted

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The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345312	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 6/21/2024

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 842

Continued From Page 1

by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to maintain accurate medical records related to transfer to the hospital for 1 of 2 sampled residents (Resident #3).

Findings included:

Resident #3 was admitted to the facility 07/01/09.

Review of Resident #3's Emergency Department Provider Note revealed he was sent to the hospital on 03/27/24 for evaluation after a fall and returned to the facility 03/27/24.

Review of Resident #3's medical record revealed there was no entry to indicate the resident was transferred to the hospital on 03/27/24 or the resident's condition at the time of transfer. The only documentation in the medical record was a nurse progress note dated 03/27/24 written by Nurse #6 regarding Resident #3's hospital transfer that read in part, "Received call from Emergency Depart nurse. Lacerated wound above left eyebrow required about 4 sutures [stitches]. CT (computerized tomography) of head, maxillofacial [face], and cervical spine [neck] were negative for injury. An x-ray of Resident #3's left knee was negative. Transportation company notified."

An interview with Nurse #6 on 06/20/24 at 4:26 PM revealed she was working as a unit manager on 03/27/24. She stated Nurse #2 asked her for assistance with getting Resident #3 sent to the hospital on 03/27/24 and she assisted her by gathering the required paperwork and arranging for transportation to the hospital. Nurse #6 stated that she was not Resident #3's assigned nurse on 03/27/23 and it was the responsibility of the assigned nurse to complete documentation detailing why the resident was transferred.

An interview with Nurse #2 on 06/21/24 at 8:00 AM revealed she was caring for Resident #3 on 03/27/24 when he needed to be transferred to the hospital. She stated she asked Nurse #6 to assist her with getting Resident #3 transferred to the hospital and she assumed Nurse #6 was completing the documentation for his transfer to the hospital. Nurse #2 stated she had been trained to write a nurse's note any time a resident was transferred to the hospital which included what time the resident left the facility, why the resident needed to be transferred to the hospital, how they were transported, and their condition at the time of the transfer. She stated Resident #3 not having a progress note regarding his transfer to the hospital on 03/27/24 was due to miscommunication between herself and Nurse #6.

An interview with the Director of Nursing (DON) on 06/20/24 at 3:07 PM revealed any time a resident was transferred to the hospital the nurse caring for the resident was responsible for writing a note which included when and how the resident left, their condition when they left the facility, and any other information relevant to the situation. She stated she was unsure why there was no note in Resident #3's medical record regarding

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345312	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 6/21/2024

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F 842	Continued From Page 2 his transfer to the hospital on 03/27/24.