	-	ID HUMAN SERVICES			FOR	M APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				<u>O. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		E SURVEY PLETED
		345463	B. WING		08	C 6/22/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				400 THOMPSON STREET		
	E CENTER OF HENDERS	SONVILLE		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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	0		
	was concuded on 08/ The following intakes NC00220565, NC002	20230, NC00220240, and e 8 complaint allegations				
F 636 SS=D	Comprehensive Asse CFR(s): 483.20(b)(1)(	ssments & Timing	F 63	6		9/25/24
	a comprehensive, acc	luct initially and periodically				
	A facility must make a assessment of a resid goals, life history and resident assessment by CMS. The assess the following: (i) Identification and d (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavio (vii) Psychological we (viii) Physical function (ix) Continence.	ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least lemographic information c. s. or patterns. ell-being. hing and structural problems.				
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 RE	TITLE		(X6) DATE

**Electronically Signed** 

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.

09/13/2024

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/17/202 FORM APPROVE OMB NO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345463	B. WING		08/22/2024		
NAME OF P	ROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, Z	IP CODE		
LIFE CAR	E CENTER OF HENDER	SONVILLE		400 THOMPSON STREET HENDERSONVILLE, NC 2879	28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE		
F 636	regarding the addition on the care areas trig the Minimum Data Set (xviii) Documentation assessment. The assi include direct observa- with the resident, as a licensed and nonlicer members on all shifts §483.20(b)(2) When t timeframes prescribe chapter, a facility mus assessment of a resid timeframes specified through (iii) of this se prescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmissio significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) (iii)Not less than once This REQUIREMENT by: Based on record rev facility failed to comp Minimum Data Set (M days of the Assessme (abbreviated as ARD	ts and procedures. ing. of summary information hal assessment performed gered by the completion of et (MDS). of participation in sessment process must ation and communication well as communication with hased direct care staff f. required. Subject to the d in §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes 13(b) of this chapter do not r days after admission, ns in which there is no the resident's physical or r purposes of this section, a return to the facility absence for hospitalization e every 12 months. is not met as evidenced iew and staff interviews, the lete a comprehensive MDS) assessment within 14 ent Reference Date and referring to the last day eriod) for 1 of 6 sampled	F	Corrective Action Resident # 6 Minimum D assessment completed 8/22/2024. Like Residents Executive Director revie progress Minimum Data that were greater than 1	and submitted on wed list of in Set assessments		

Facility ID: 923244

If continuation sheet Page 2 of 13

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	· · · ·	OMPLETED
			A. BUILDING			С
		345463	B. WING			08/22/2024
	ROVIDER OR SUPPLIER	040400		STREET ADDRESS, CITY, STATE, Z		08/22/2024
NAME OF F	NOVIDER OR SUFFLIER			400 THOMPSON STREET		
LIFE CAR	E CENTER OF HENDER	SONVILLE		HENDERSONVILLE, NC 287	02	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE	(X5) COMPLETIO DATE
F 636	Continued From pag	e 2	F 63	36		
	Findings included:			date. MDS assessment	ts to be completed	
	Ŭ			and submitted.	•	
	Resident #6 was adn	nitted to the facility on		Systemic Changes		
	12/09/22.			Full time MDS coordina		
				8/13/2024. Executive D		
		#6's electronic health record		re-educated Director of		
		IDS assessment with an		Coordinator on Director	0 0	
	ARD of 08/01/24 was	s noted as "in progress."		back up for MDS and im		
	During a telephone ir	nterview on 08/22/24 at 6:09		completing quarterly ME within 14 days of Asses		
		IDS Consultant confirmed		Date (ARD and referring		
	· ·	I MDS assessment dated		observation period) on 8	• •	
		mpleted within the regulatory		Monitoring		
		ined the facility had been		Executive Director and/	or designee to	
		dinator for some time and the		review 5 random reside	nt charts for MDS	
	staff that had been a	ssisting from other facilities		assessment completed	within 14 days of	
		ent MDS assessments to		ARD date weekly x 4 we		
		eing completed late. The		resident charts weekly >		
		sultant stated he was actively		random resident chart w		
		ng the MDS assessments		Executive Director will r		
		te and hoped to have them		of audits for trends and	1 0	
	all caught up by next	week.		to the QAPI committee		
	During an interview of	on 08/22/24 at 7:00 PM, the		recommendations, as a Completion Date: 9/25/2		
		she realized there was an				
	issue with the timely					
		the did an audit for the Plan				
		e recertification survey on				
		d the issue was discussed				
	with the Corporate M	IDS Consultant but they had				
		to get them all caught back				
	•	or felt the breakdown was				
		having one permanent MDS				
		ing assessments and now				
	that they have hired					
		uld be able to stay caught up				
	with completing MDS					
	MDS assessments to	it was her expectation for				

If continuation sheet Page 3 of 13

STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	PLETED
		345463	B. WING				C / <b>22/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAR	E CENTER OF HENDER	SONVILLE			ENDERSONVILLE, NC 28792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	LD BE COMP	
F 636			F	636			
F 638 SS=D			F	638			9/25/24
	and approved by CM once every 3 months This REQUIREMENT by: Based on record rev facility failed to comp Set (MDS) assessme Assessment Referen ARD and referring to observation period) fo (Residents #2, #3, an Findings included: 1. Resident #2 was a 08/30/16. Review of Resident # (EHR) on 08/22/24 re assessment with an A as "in progress." During a telephone in PM, the Corporate M Resident #2's quarter 07/23/24 was not cont timeframe. He explai without a MDS Coord staff that had been as had focused on curre	<ul> <li>a resident using the ument specified by the State S not less frequently than</li> <li>.</li> <li>.<td></td><td></td><td>Corrective Action Resident #2 Minimum Data Set (MDS) assessment completed and submitted of 9/9/2024. Resident #5 MDS assessment complet and submitted on 9/13/2024. Resident #3 MDS assessment complet and submitted on 9/13/2024. Like Residents Executive Director reviewed current residents to ensure that each had an M assessment completed within at least 3 months and within 14 days of Assessm Reference Date Systemic Changes Full time MDS coordinator hired on 8/13/2024. Executive Director re-educated Director of Nursing and MI Coordinator on Director of Nursing beir back up for MDS and importance of completing quarterly MDS assessments within 14 days of Assessment Reference Date (ARD and referring to last day of to observation period) at least every 3 months on 8/22/2024. Monitoring Executive Director and/or designee to</td><td>ed IDS ent DS ing s ce</td><td></td></li></ul>			Corrective Action Resident #2 Minimum Data Set (MDS) assessment completed and submitted of 9/9/2024. Resident #5 MDS assessment complet and submitted on 9/13/2024. Resident #3 MDS assessment complet and submitted on 9/13/2024. Like Residents Executive Director reviewed current residents to ensure that each had an M assessment completed within at least 3 months and within 14 days of Assessm Reference Date Systemic Changes Full time MDS coordinator hired on 8/13/2024. Executive Director re-educated Director of Nursing and MI Coordinator on Director of Nursing beir back up for MDS and importance of completing quarterly MDS assessments within 14 days of Assessment Reference Date (ARD and referring to last day of to observation period) at least every 3 months on 8/22/2024. Monitoring Executive Director and/or designee to	ed IDS ent DS ing s ce	

Facility ID: 923244

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	· · /		· · · ·	OMPLETED	
						С	
		345463	B. WING			08/22/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LIFE CAR	E CENTER OF HENDER	SONVILLE		400 THOMPSON STREET 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 OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETIO DATE		
F 638	Continued From page	e 4	F 63	8			
	Corporate MDS Cons	sultant stated he was actively		review 5 random resident char	ts for MDS		
	÷ .	g the MDS assessments		assessment completed at leas	-		
	-	te and hoped to have them		months within 14 days of ARD			
	all caught up by next	week.		weekly x 4 weeks, 3 random re charts weekly x 4 weeks, and			
	During an interview o	n 08/22/24 at 7:00 PM, the		resident chart weekly x 4 week			
		she realized there was an		Executive Director will review			
	issue with the timely	-		of audits for trends and will rep	-		
		he did an audit for the Plan		to the QAPI committee for furt			
		e recertification survey on I the issue was discussed		recommendations, as appropri Completion Date: 9/25/2024	ale.		
		DS Consultant but they had					
		to get them all caught back					
	-	or felt the breakdown was					
		having one permanent MDS					
	that they have hired a	ng assessments and now					
	•	uld be able to stay caught up					
	with completing MDS						
		t was her expectation for					
	MDS assessments to regulatory timeframes	be completed within the S.					
	2. Resident #5 was a 05/15/20.	admitted to the facility on					
	Review of Resident #	5's Electronic Health Record					
	, ,	evealed a quarterly MDS					
	assessment with an A as "in progress."	ARD of 07/26/24 was noted					
	<b>v</b> .	terview on 08/22/24 at 6:09 DS Consultant confirmed					
	Resident #5's quarter	ly MDS assessment dated					
		ined the facility had been					
	without a MDS Coord	linator for some time and the					
	staff that had been as had focused on curre	ssisting from other facilities					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED
		345463	B. WING				C / <b>22/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
LIFE CAR	E CENTER OF HENDER	SONVILLE			400 THOMPSON STREET HENDERSONVILLE, NC 28792		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	COMPLETION DATE
F 638	Continued From page	2.5	F	638	8		
	• • • • • • • • • • • • • • • • • • •	ing completed late. The		000	Ŭ		
	-	sultant stated he was actively					
		g the MDS assessments te and hoped to have them					
	all caught up by next	•					
	During an interview o	n 08/22/24 at 7:00 PM, the					
	Administrator stated s	she realized there was an					
	issue with the timely of	completion of MDS he did an audit for the Plan					
		e recertification survey on					
		I the issue was discussed					
		DS Consultant but they had to get them all caught back					
	up. The Administrato	r felt the breakdown was					
		having one permanent MDS ng assessments and now					
	that they have hired a	-					
	Coordinator, they wou with completing MDS	uld be able to stay caught up					
		t was her expectation for					
	MDS assessments to	be completed within the					
	regulatory timeframes	3.					
	3. Resident #3 was a 03/16/22.	admitted to the facility on					
	Review of Resident #	3's Electronic Health Record					
		evealed a quarterly MDS					
	assessment with an <i>P</i> as "in progress."	ARD of 08/06/24 was noted					
	During a telephone in	terview on 08/22/24 at 6:09					
	PM, the Corporate M	DS Consultant confirmed					
		ly MDS assessment dated npleted within the regulatory					
	timeframe. He explai	ned the facility had been					
		linator for some time and the sisting from other facilities					

Facility ID: 923244

If continuation sheet Page 6 of 13

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	
		345463	B. WING				22/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAR	E CENTER OF HENDERS	SONVILLE			00 THOMPSON STREET 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 638 F 640 SS=B	had focused on current prevent more from be Corporate MDS Consist working on completing that were currently lat all caught up by next. During an interview of Administrator stated as issue with the timely of assessments when sh of Correction from the 07/19/24. She stated with the Corporate MI not had enough time up. The Administrato due primarily to only f Coordinator completing that they have hired as Coordinator, they wou with completing MDS Administrator stated if MDS assessments to regulatory timeframess Encoding/Transmitting CFR(s): 483.20(f)(1)-0 §483.20(f) Automated requirement- §483.20(f) (1) Encodir a facility completes a facility must encode the each resident in the fa (i) Admission assessment (ii) Annual assessment (iii) Significant change (iv) Quarterly review a	nt MDS assessments to ing completed late. The ultant stated he was actively g the MDS assessments is and hoped to have them week. In 08/22/24 at 7:00 PM, the she realized there was an completion of MDS ne did an audit for the Plan e recertification survey on the issue was discussed DS Consultant but they had to get them all caught back r felt the breakdown was having one permanent MDS ng assessments and now in additional MDS uld be able to stay caught up assessments. The t was her expectation for be completed within the s. g Resident Assessments (4) d data processing ng data. Within 7 days after resident's assessment, a he following information for acility: ment. ht updates. e in status assessments.		638			9/25/24

Facility ID: 923244

If continuation sheet Page 7 of 13

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345463	B. WING				C 22/2024
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
	E CENTER OF HENDER	SONVILLE			400 THOMPSON STREET 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 640	is no admission asset §483.20(f)(2) Transm after a facility comple a facility must be cap CMS System information contained in the MDS standard record layou and that passes stand CMS and the State. §483.20(f)(3) Transm 14 days after a facility assessment, a facility encoded, accurate, at the CMS System, incl (i) Admission assessment (ii) Annual assessment (ii) Significant correct (v) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, ar (viii) Background (fac initial transmission of does not have an adr §483.20(f)(4) Data for transmit data in the for for a State which has by CMS, in the formation approved by CMS.	and death. A-sheet) information, if there assment. itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident a format that conforms to ats and data dictionaries, dardized edits defined by ittal requirements. Within y completes a resident's must electronically transmit and complete MDS data to luding the following: nent. nt. e in status assessment. tion of prior full assessment. ion of prior quarterly a upon a resident's transfer, and death. e-sheet) information, for an MDS data on resident that	F	640			
	-	iew and staff interviews, the			Corrective Action		

Facility ID: 923244

If continuation sheet Page 8 of 13

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	. 0938-03 SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPL	
					C	)
		345463	B. WING			22/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
LIFE CAR	E CENTER OF HENDER	SONVILLE		400 THOMPSON STREET HENDERSONVILLE, NC 28792	2	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	F CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLETIO DATE
F 640	Continued From pag	e 8	F 64	40		
	facility failed to comp	lete a discharge-return		a. Resident #5 Minimum	Data Set (MDS)	
		Data Set (MDS) within 14		assessment for entry on	· /	
		e date and an entry tracking		completed and submitted		
		s of the admission date for 1		b. Resident # 5 MDS ass		
	of 6 sampled residen	its (Resident #5).		discharge on 7/23/24 con submitted on 9/13/2024.	npleted and	
	Findings included:			Like Residents		
	T mangs molaca.			Executive Director review	red last 30 days	
	Resident #5 was adr	nitted to the facility on		of admissions and discha		
	05/15/20.	2		that each resident had ar	•	
				assessment completed a	nd submitted to	
		5's electronic health record		reflect the discharge.		
	on 08/22/24 revealed	the following:		Systemic Changes Full time MDS coordinate	r hirod on	
	a. A discharge-retur	n anticipated MDS		8/13/2024. Executive Dir		
		7/23/24 noted a status of "in		re-educated Director of N		
	progress."			Coordinator on Director of		
	b. An entry tracking	record dated 07/24/24 noted		back up for MDS and imp	ortance of	
	a status of "in progre	ss."		completing MDS assessr		
	Duning a talankana i			and discharge within 14 c	lays on	
		nterview on 08/22/24 at 6:09 IDS Consultant confirmed		8/22/2024. Monitoring		
		racking record and discharge		Executive Director and/or	designee to	
		ere not completed within the		review admissions and di	•	
		. He explained the facility		resident charts for MDS a	•	
	had been without a N	IDS Coordinator for some		completed within 14 days	of ARD date	
		at had been assisting from		weekly x 4 weeks, 3 resid		
		cused on current MDS		weekly x 4 weeks, and 1	resident chart	
	assessments to prev	ent more from being Corporate MDS Consultant		weekly x 4 weeks. Executive Director will rev	view the results	
		ly working on completing the		of audits for trends and w		
		hat were currently late and		to the QAPI committee for		
		all caught up by next week.		recommendations, as ap Completion Date: 9/25/20	-	
	During an interview of	on 08/22/24 at 7:00 PM, the				
		she realized there was an				
	issue with the timely	-				
		she did an audit for the Plan				
	of Correction from th	e recertification survey on				

Facility ID: 923244

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       345463       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       08/22/202		MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	D: 10/17/2024 M APPROVED D. 0938-0391
345463         B. WING         08/22/202           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         400 THOMPSON STREET	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, í			(X3) DATE COMF	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         400 THOMPSON STREET			345463	B. WING				
400 THOMPSON STREET	NAME OF P	PROVIDER OR SUPPLIER		-	STREET ADDRESS,	CITY, STATE, ZIP CODE		-
LIFE CARE CENTER OF HENDERSONVILLE HENDERSONVILLE, NC 28792	LIFE CAR	RE CENTER OF HENDERS	SONVILLE					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	K (EACH	I CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPR	ЗE	(X5) COMPLETION DATE
F 640       Continued From page 9       F 640         07/19/24. She stated the issue was discussed with the Corporate MDS Consultant but they had not had enough time to get them all caught back up. The Administrator felt the breakdown was due primarily to only having one permanent MDS Coordinator completing assessments and now that they have hired an additional MDS Coordinator, they would be able to stay caught up with completing MDS assessments. The Administrator stated it was her expectation for MDS assessments to be completed within the regulatory timeframes.       F 640	F 761	07/19/24. She stated with the Corporate MI not had enough time up. The Administrato due primarily to only h Coordinator completin that they have hired a Coordinator, they wou with completing MDS Administrator stated in MDS assessments to regulatory timeframes Label/Store Drugs an CFR(s): 483.45(g)(h)( §483.45(g) Labeling o Drugs and biologicals labeled in accordance professional principles appropriate accessor instructions, and the e applicable. §483.45(h) Storage o §483.45(h)(1) In accor Federal laws, the faci biologicals in locked of temperature controls, personnel to have accor \$483.45(h)(2) The face locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 at abuse, except when t	the issue was discussed DS Consultant but they had to get them all caught back r felt the breakdown was having one permanent MDS ing assessments and now an additional MDS uld be able to stay caught up assessments. The t was her expectation for be completed within the s. d Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to he facility uses single unit					9/12/24

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	OF DEFICIENCIES	MEDICAID SERVICES	(Y2) MI II T			OMB NO. (X3) DATE S	
	CORRECTION	IDENTIFICATION NUMBER:	. ,			COMPL	
				_		С	
		345463	B. WING			08/2	2/2024
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	E CENTER OF HENDER			40	0 THOMPSON STREET		
	E CENTER OF HENDER	SONVILLE		HE	ENDERSONVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 761	Continued From pag	e 10	F7	61			
		nimal and a missing dose can		01			
	be readily detected.						
	•	T is not met as evidenced					
	by:						
		on, staff interviews and			Corrective Action		
		acility failed to remove an			All items identified to be expired or		
		ion from the medication cart			outside of manufacturer⊡s guidelines		
		ufacturer's guidelines and			were disposed of by Director of Nursing on 8/22/2024.		
	solutions from anothe	red antiseptic wound care			Like Residents		
		manufacturer's expiration			All medication carts, medication rooms,		
	date for 2 of 5 medic			central supply storage areas reviewed b	v		
		hecks (200 halls and 600			Director of Nursing on 8/22/2024. Any	·	
	halls).				items that were found to be expired,		
	,				outside of manufacturer⊡s guidelines, c	or	
	The findings included	d:			within close proximity of expiration were	;	
					disposed of.		
		s package inserts for			Like Residents		
		os revealed an unopened			All licensed nurses re-educated on		
		ed under refrigeration			label/storage of medication and		
		ature of 36° to 46° Fahrenheit			manufacturer s guidelines on 8/22/202	4,	
		m light. Once it was opened, e stored at room temperature			prior to beginning next shift. Monitoring		
	up to 77° F for up to				Director of Nursing and/or designee to		
					audit medication carts and medication		
	A medication storage	e audit was conducted on			storage areas ten times weekly x 2		
	-	I for 200 halls medication			weeks, six times weekly x 4 weeks, and		
	cart in the presence	of Nurse #1. One opened			then one time weekly x 4 weeks Directo		
		0.005% eye drops was			of Nursing and/or designee to audit		
	found in the medicat				central supply three times weekly x 4		
	temperature and rea	•			weeks, 2 times weekly x 4 weeks and		
	-	bel indicated it was opened			then 1 time weekly x 4 weeks.		
	on 04/28/24.				Executive Director will review the results		
	An interview was cor	nducted with Nurse #1 on			of audits for trends and will report findin to the QAPI committee for further	95	
		<i>I</i> . She acknowledged that the			recommendations, as appropriate.		
		eye drops was opened and			Completion Date: 9/12/2024		
		tion cart since 04/28/24. She					
		he eye drops when she					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 10/17/2024 APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE SURVEY COMPLETED		SURVEY LETED
		345463	B. WING			C 08/22/2024		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LIFE CAR	E CENTER OF HENDERS	SONVILLE			00 THOMPSON STREET IENDERSONVILLE, 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BI		(X5) COMPLETION DATE
F 761	did not discard it as si in the medication cart until the manufacturer 2026. b. During a medicatio on 08/22/24 at 11:09. cart in the presence of bottle containing appr Povidone lodine 10 % 10/31/23 was found in ready to be used. An interview was con 08/22/24 at 11:12 AM solution was for woun used for quite a while checked the medication did not know why she She acknowledged the should be removed from was expired. During an interview can 11:25 AM, the Director Latanoprost should be until it was opened. Of be stored in room term She stated that the far in-service after the pro- administrative staff has carts and storage roo auditing tools. She did staff missed the expire solution. It was her ex- remain free of expired	on cart in the morning. She he thought it could be stored under room temperature 's expiration date in June In storage audit conducted AM for 600 halls medication of Nurse #2, an opened oximate 90 milliliters (ml) of a solution expired on the medication cart and ducted with Nurse #2 on . She stated the topical d care and it had not been . She explained she on cart in the morning and missed the topical solution. at the topical solution om the medication cart as it onducted on 08/22/24 at r of Nursing (DON) stated e stored in the refrigerator ince it was opened, it could aperature for up to 42 days. cility had conducted evious survey and the ad audited the medication ms as outlined in the d not understand why the ed eye drops and the topical spectation for the facility to a medications.	F	761				
	An interview was con	ducted with the						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						RINTED: 10/17/2024 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X:	3) DATE SURVEY COMPLETED
345463		345463	B. WING			C 08/22/2024
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CARE CENTER OF HENDERSONVILLE				400 THOMPSON STREET HENDERSONVILLE, 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	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CC		(X5) COMPLETION DATE
F 761	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 7	PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO		

Event ID: 2JNP11

Facility ID: 923244

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