STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannoounced complaint investigation survey was concuded on 08/22/24. Event ID# 2JNP11. The following intakes were investigated: NC00220565, NC00220230, NC00220240, and NC00220148. 8 of the 8 complaint allegations did not result in a deficiency.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications.	F 636		9/25/24

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

Electronically Signed | 09/13/2024

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 636	Continued From page 1 (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment within 14 days of the Assessment Reference Date (abbreviated as ARD and referring to the last day of the assessment period) for 1 of 6 sampled residents (Resident #6).	F 636	Corrective Action Resident # 6 Minimum Data Set (MDS) assessment completed and submitted on 8/22/2024. Like Residents Executive Director reviewed list of in progress Minimum Data Set assessments that were greater than 14 days past ARD	

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F 636	Continued From page 2 Findings included: Resident #6 was admitted to the facility on 12/09/22. Review of Resident #6's electronic health record revealed an annual MDS assessment with an ARD of 08/01/24 was noted as "in progress." During a telephone interview on 08/22/24 at 6:09 PM, the Corporate MDS Consultant confirmed Resident #6's annual MDS assessment dated 08/01/24 was not completed within the regulatory timeframe. He explained the facility had been without a MDS Coordinator for some time and the staff that had been assisting from other facilities had focused on current MDS assessments to prevent more from being completed late. The Corporate MDS Consultant stated he was actively working on completing the MDS assessments that were currently late and hoped to have them all caught up by next week. During an interview on 08/22/24 at 7:00 PM, the Administrator stated she realized there was an issue with the timely completion of MDS assessments when she did an audit for the Plan of Correction from the recertification survey on 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	F 636	date. MDS assessments to be completed and submitted. Systemic Changes Full time MDS coordinator hired on 8/13/2024. Executive Director re-educated Director of Nursing and MDS Coordinator on Director of Nursing being 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 the observation period) on 8/22/2024. Monitoring Executive Director and/or designee to review 5 random resident charts for MDS assessment completed within 14 days of ARD date weekly x 4 weeks, 3 random resident charts weekly x 4 weeks, and 1 random resident chart weekly x 4 weeks. Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate. Completion Date: 9/25/2024	

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F 636	Continued From page 3 regulatory timeframes.	F 636		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (abbreviated as ARD and referring to the last day of the observation period) for 3 of 6 sampled residents (Residents #2, #3, and #5). Findings included: 1. Resident #2 was admitted to the facility on 08/30/16. Review of Resident #2's Electronic Health Record (EHR) on 08/22/24 revealed a quarterly MDS assessment with an ARD of 07/23/24 was noted as "in progress." During a telephone interview on 08/22/24 at 6:09 PM, the Corporate MDS Consultant confirmed Resident #2's quarterly MDS assessment dated 07/23/24 was not completed within the regulatory timeframe. He explained the facility had been without a MDS Coordinator for some time and the staff that had been assisting from other facilities had focused on current MDS assessments to prevent more from being completed late. The	F 638	Corrective Action Resident #2 Minimum Data Set (MDS) assessment completed and submitted on 9/9/2024. Resident #5 MDS assessment completed and submitted on 9/13/2024. Resident #3 MDS assessment completed and submitted on 9/13/2024. Like Residents Executive Director reviewed current residents to ensure that each had an MDS assessment completed within at least 3 months and within 14 days of Assessment Reference Date Systemic Changes Full time MDS coordinator hired on 8/13/2024. Executive Director re-educated Director of Nursing and MDS Coordinator on Director of Nursing being 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 the observation period) at least every 3 months on 8/22/2024. Monitoring Executive Director and/or designee to	9/25/24

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F 638	Continued From page 4 Corporate MDS Consultant stated he was actively working on completing the MDS assessments that were currently late and hoped to have them all caught up by next week. During an interview on 08/22/24 at 7:00 PM, the Administrator stated she realized there was an issue with the timely completion of MDS assessments when she did an audit for the Plan of Correction from the recertification survey on 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. 2. Resident #5 was admitted to the facility on 05/15/20. Review of Resident #5's Electronic Health Record (EHR) on 08/22/24 revealed a quarterly MDS assessment with an ARD of 07/26/24 was noted as "in progress." During a telephone interview on 08/22/24 at 6:09 PM, the Corporate MDS Consultant confirmed Resident #5's quarterly MDS assessment dated 07/26/24 was not completed within the regulatory timeframe. He explained the facility had been without a MDS Coordinator for some time and the staff that had been assisting from other facilities had focused on current MDS assessments to	F 638	review 5 random resident charts for MDS assessment completed at least every 3 months within 14 days of ARD date weekly x 4 weeks, 3 random resident charts weekly x 4 weeks, and 1 random resident chart weekly x 4 weeks. Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate. Completion Date: 9/25/2024	

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F 638	Continued From page 5	F 638		

prevent more from being completed late. The Corporate MDS Consultant stated he was actively working on completing the MDS assessments that were currently late and hoped to have them all caught up by next week.

During an interview on 08/22/24 at 7:00 PM, the Administrator stated she realized there was an issue with the timely completion of MDS assessments when she did an audit for the Plan of Correction from the recertification survey on 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.

3. Resident #3 was admitted to the facility on 03/16/22.

Review of Resident #3's Electronic Health Record (EHR) on 08/22/24 revealed a quarterly MDS assessment with an ARD of 08/06/24 was noted as "in progress."

During a telephone interview on 08/22/24 at 6:09 PM, the Corporate MDS Consultant confirmed Resident #3's quarterly MDS assessment dated 08/06/24 was not completed within the regulatory timeframe. He explained the facility had been without a MDS Coordinator for some time and the staff that had been assisting from other facilities

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F 638	Continued From page 6 had focused on current MDS assessments to prevent more from being completed late. The Corporate MDS Consultant stated he was actively working on completing the MDS assessments that were currently late and hoped to have them all caught up by next week. During an interview on 08/22/24 at 7:00 PM, the Administrator stated she realized there was an issue with the timely completion of MDS assessments when she did an audit for the Plan of Correction from the recertification survey on 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 638		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer,	F 640		9/25/24

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F 640	Continued From page 7 reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 640	Corrective Action	

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F 640	Continued From page 8 facility failed to complete a discharge-return anticipated Minimum Data Set (MDS) within 14 days of the discharge date and an entry tracking record within 14 days of the admission date for 1 of 6 sampled residents (Resident #5). Findings included: Resident #5 was admitted to the facility on 05/15/20. Review of Resident #5's electronic health record on 08/22/24 revealed the following: a. A discharge-return anticipated MDS assessment dated 07/23/24 noted a status of "in progress." b. An entry tracking record dated 07/24/24 noted a status of "in progress." During a telephone interview on 08/22/24 at 6:09 PM, the Corporate MDS Consultant confirmed Resident #5's entry tracking record and discharge MDS assessment were not completed within the regulatory timeframe. He explained the facility had been without a MDS Coordinator for some time and the staff that had been assisting from other facilities had focused on current MDS assessments to prevent more from being completed late. The Corporate MDS Consultant stated he was actively working on completing the MDS assessments that were currently late and hoped to have them all caught up by next week. During an interview on 08/22/24 at 7:00 PM, the Administrator stated she realized there was an issue with the timely completion of MDS assessments when she did an audit for the Plan of Correction from the recertification survey on	F 640	a. Resident #5 Minimum Data Set (MDS) assessment for entry on 7/24/24 completed and submitted on 8/27/24. b. Resident # 5 MDS assessment for discharge on 7/23/24 completed and submitted on 9/13/2024. Like Residents Executive Director reviewed last 30 days of admissions and discharges to review that each resident had an MDS assessment completed and submitted to reflect the discharge. Systemic Changes Full time MDS coordinator hired on 8/13/2024. Executive Director re-educated Director of Nursing and MDS Coordinator on Director of Nursing being back up for MDS and importance of completing MDS assessments for entry and discharge within 14 days on 8/22/2024. Monitoring Executive Director and/or designee to review admissions and discharges for 5 resident charts for MDS assessment completed within 14 days of ARD date weekly x 4 weeks, 3 resident charts weekly x 4 weeks, and 1 resident chart weekly x 4 weeks. Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate. Completion Date: 9/25/2024	

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F 640	Continued From page 9 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 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		9/12/24

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F 761	Continued From page 10 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews, the facility failed to remove an opened eye medication from the medication cart as specified by manufacturer's guidelines and failed to discard expired antiseptic wound care solutions from another medication cart in accordance with the manufacturer's expiration date for 2 of 5 medication carts observed during medication storage checks (200 halls and 600 halls). The findings included: a. The manufacturer's package inserts for Latanoprost eye drops revealed an unopened bottle should be stored under refrigeration between the temperature of 36° to 46° Fahrenheit (F) and protected from light. Once it was opened, Latanoprost could be stored at room temperature up to 77° F for up to six weeks. A medication storage audit was conducted on 08/22/24 at 10:10 AM for 200 halls medication cart in the presence of Nurse #1. One opened bottle of Latanoprost 0.005% eye drops was found in the medication cart under room temperature and ready to be used. The handwriting on the label indicated it was opened on 04/28/24. An interview was conducted with Nurse #1 on 08/22/24 at 10:11 AM. She acknowledged that the bottle of Latanoprost eye drops was opened and stored in the medication cart since 04/28/24. She stated that she saw the eye drops when she	F 761	Corrective Action All items identified to be expired or outside of manufacturer□s guidelines were disposed of by Director of Nursing on 8/22/2024. Like Residents All medication carts, medication rooms, central supply storage areas reviewed by Director of Nursing on 8/22/2024. Any items that were found to be expired, outside of manufacturer□s guidelines, or within close proximity of expiration were disposed of. Like Residents All licensed nurses re-educated on label/storage of medication and manufacturer□s guidelines on 8/22/2024, prior to beginning next shift. Monitoring Director of Nursing and/or designee to audit medication carts and medication storage areas ten times weekly x 2 weeks, six times weekly x 4 weeks, and then one time weekly x 4 weeks Director of Nursing and/or designee to audit central supply three times weekly x 4 weeks, 2 times weekly x 4 weeks and then 1 time weekly x 4 weeks. Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate. Completion Date: 9/12/2024	

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F 761	Continued From page 11	F 761		

checked the medication cart in the morning. She did not discard it as she thought it could be stored in the medication cart under room temperature until the manufacturer's expiration date in June 2026.

b. During a medication storage audit conducted on 08/22/24 at 11:09 AM for 600 halls medication cart in the presence of Nurse #2, an opened bottle containing approximate 90 milliliters (ml) of Povidone Iodine 10 % solution expired on 10/31/23 was found in the medication cart and ready to be used.

An interview was conducted with Nurse #2 on 08/22/24 at 11:12 AM. She stated the topical solution was for wound care and it had not been used for quite a while. She explained she checked the medication cart in the morning and did not know why she missed the topical solution. She acknowledged that the topical solution should be removed from the medication cart as it was expired.

During an interview conducted on 08/22/24 at 11:25 AM, the Director of Nursing (DON) stated Latanoprost should be stored in the refrigerator until it was opened. Once it was opened, it could be stored in room temperature for up to 42 days. She stated that the facility had conducted in-service after the previous survey and the administrative staff had audited the medication carts and storage rooms as outlined in the auditing tools. She did not understand why the staff missed the expired eye drops and the topical solution. It was her expectation for the facility to remain free of expired medications.

An interview was conducted with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 12 Administrator on 08/22/24 at 6:51 PM. She expected the facility to remain free of expired medication and discard eye drops in a timely manner as specified by the manufacturer's guidelines.	F 761		