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THE LAURELS OF HENDERSONVILLE	**290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792**

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 12/12/24 through 12/13/24. The survey team returned to the facility to validate the credible allegation on 12/17/24. Therefore, the exit date was changed to 12/17/24. Event ID: GFFZ11. The following intakes were investigated: NC00216508, NC00216515, NC00220555, NC00224374 and NC00224815. Intake NC00224815 resulted in immediate jeopardy. 1 of the 7 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/18/24 and was removed on 12/15/24. A partial extended survey was conducted.	F 000		
F 689 SS=J	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:	F 689		12/17/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 01/06/2025

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 Based on record review, and interviews with staff, Medical Director, and Medical Examiner, the facility failed to ensure Resident #1 was supervised during a shower. On 11/18/24 Nurse Aide (NA) #1 had Resident #1, who had dementia and impulsiveness, in the shower room in his unlocked wheelchair. Resident #1 removed his shoes and was removing his shirt when NA #1 turned her back and stepped away from Resident #1 to go to a linen cabinet. When NA #1 turned around, Resident #1 stood up from his wheelchair, lost his balance and fell. Resident #1 immediately verbalized pain. He was transferred to the Emergency Department (ED) and was diagnosed with a right femoral neck (thigh bone) fracture that required surgical repair. Resident #1 experienced acute blood loss anemia after surgery that required a blood transfusion and developed swallowing difficulties. He returned to the facility on 11/25/24. He was admitted to hospice and passed away on 12/3/24 at the facility. This deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents (#1). Immediate jeopardy began on 11/18/24 when NA #1 turned her back and stepped away from Resident #1 in the shower room. Immediate jeopardy was removed on 12/15/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective and to address the deficient practice. Findings included:	F 689	The facility will continue to ensure that residents are supervised during showers. 1. Resident #1 was assessed by the Nurse and Medical Doctor (MD) and sent to the Emergency Department on November 18, 2024. Nurse Aide #1 (a member of the facility shower team) was educated by the Director of Nursing (DON) on November 21, 2024 on ensuring that she does not turn away from the resident in the shower room while performing showering and bathing tasks. 2. A 100% review of all falls occurring in the last 60 days was conducted by the DON and Assistant Director of Nursing (ADON) on November 27, 2024 to ensure there were no repeated patterns related to falls in the shower room. There were no other concerns identified relating to this isolated incident. No additional opportunities for staff education were identified as a result of this review. All residents identified as being at risk for falls had care plan reviews conducted by the DON and ADON on December 14, 2024 to ensure that fall interventions were appropriate related to assistive devices and level of supervision. 3. All nurse aides on the facility shower team were educated by the DON as of	

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F 689	Continued From page 2 Resident #1 was admitted to the facility on 6/7/24. His diagnoses included dementia, cerebral infarction (CVA) muscle weakness, difficulty in walking, osteoarthritis of right knee, dizziness and giddiness, lack of coordination, and left artificial hip joint. Resident #1 had a fall care plan dated 6/7/24 in place that read, at risk for fall related to injury and falls, extensive fall history, unsteady on feet, impaired bed mobility, incontinence, psychotropic medication regimen, and impulsive. The care plan interventions included: wheel chair set and locked at bedside, medical doctor evaluation, administer medications as ordered, encourage to use call bell for assistance, evaluation for right grab bar, bowel and bladder program, anticipate and meet needs as needed, encourage to wear appropriate footwear as needed, keep the environment as safe as possible, provide safety and assistive devices put the call light within reach and encourage to use it. The quarterly Minimum Data Set (MDS) assessment dated 10/16/24 revealed Resident #1 had moderate cognitive impairment. He was not documented on the MDS as having behaviors or rejections of care. He was documented as having functional limitation in range of motion to the upper extremity on one side. The MDS documented Resident #1 required substantial/ maximal assistance with shower/ bathing, upper body/ lower body dressing, and putting on/ taking off footwear. The MDS revealed Resident #1 required supervision or touching assistance for transfers. He was not documented for falls. Resident #1 had care plan interventions dated	F 689	December 4, 2024 on ensuring that staff do not turn away from the resident in the shower room while performing showering and bathing tasks. All facility nurse aides and licensed nurses were educated by the DON as of December 12, 2024 on ensuring that staff do not turn away from the resident in the shower room while performing showering and bathing tasks. All facility nurse aides and licensed nurses were educated in-person as of December 14, 2024, by the Administrator or DON or trained designee on the facility fall management policy with an emphasis on ensuring assistive devices are in place and adequate supervision provided to prevent falls. Any newly hired nurse aide or licensed nurse after 12/14/24 will receive the education prior to working their first shift on the floor and the Administrator will be responsible for ensuring this action. 4. A QA monitoring tool will be utilized to ensure ongoing compliance. Beginning December 15th, 2024, the DON or Trained Designee will observe residents being transferred to ensure assistive devices are in place and adequate supervision provided to prevent falls. The audits are at the following frequency: a. 5 residents per day for 5 days a week for 4 weeks; b. 5 residents per day for 3 days a week for 4 weeks;	

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F 689	Continued From page 3 10/28/24 that read, selfcare- substantial/ maximal assistance with upper body dressing, lower body dressing, putting on/taking off footwear, bathing. An intervention for mobility dated 10/28/24 indicated partial/ moderate assistance was needed for transfers. A physician progress note from 11/14/24 indicated Resident #1 had pain to his left hip chronically. An incident report dated 11/18/24 for Resident #1 completed by the Director of Nursing (DON) said staff had brought Resident #1 into the shower room to get a shower. The report indicated the "shower aide" had pulled Resident #1 up to the metal bar on the wall and had started taking his shoes and shirt off. The report said Resident #1 had stopped the staff member stating he would take off his shirt. The report indicated the aide turned to throw trash in the trash can beside the resident. Resident #1 stood up to take his shirt off, and immediately fell landing on his right side. The incident report said Resident #1 was assessed by a nurse and he had horrible pain in his right leg. The report stated 911 was called. An interview was conducted with NA #1 on 12/12/24 at 2:25 PM. NA #1 explained she was part of the facility's shower team and performed the showers for the residents on the 200 Hall, where Resident #1 resided. She said she was familiar with Resident #1 and had assisted with his showers previously. She explained Resident #1 had a history of falls and was impulsive. She further explained, most of his prior falls had resulted from him standing up on his own or not calling for help. She stated Resident #1 had not stood up before on his own in the shower room	F 689	c. 10 residents per week for 4 weeks. 5. Audit results will be reported to the Quality Assurance Committee during monthly meetings for 3 months or until resolved and additional education/training will be provided for any issues identified. The Administrator will be responsible to collect the data and bring to the facility QAPI meeting. 6. Date of Compliance: 12/17/2024	

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F 689	Continued From page 4 before the incident. NA #1 recalled she had assisted Resident #1 with his shower on 11/18/24. She stated she had taken him into the shower room in his wheelchair to the last shower stall. NA #1 recalled Resident #1 had been positioned in his wheelchair at the grab bar located on the wall at the last shower stall. She said his wheelchair was unlocked. She explained she removed his shoes, but he still had his socks on, and she had instructed him to take off his shirt. NA #1 stated while Resident #1 removed his shirt, she turned around for one to two minutes and walked to a cabinet to get supplies. She recalled she was getting wash cloths. She said when she turned back around, Resident #1 was standing. NA #1 stated Resident #1 lost his balance and fell onto the floor landing on his side. NA #1 could not remember what side Resident #1 had fallen onto. She said after Resident #1 fell he said his hip was hurting. NA #1 explained she did not move Resident #1 and got Nurse #1. An interview was conducted with Nurse #1 on 12/12/24 at 4:15 PM. She stated she had been the assigned nurse for Resident #1 on 11/18/24. She recalled Resident #1 fell in the shower and NA #1 got her off the hall to assess Resident #1. Nurse #1 said Resident #1 complained of pain to his hip and she got the Assistant Director of Nursing (ADON) to further assess him. She explained Resident #1 had turned himself onto his left side because his right hip was hurting, and he was trying to get the pressure off it. Nurse #1 said a physician came into the shower room to assess Resident #1. She could not recall which physician had assessed Resident #1. Nurse #1 stated NA #1 did not say what had happened during Resident #1's fall in the shower room and she still did not know what had happened. Nurse	F 689		

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F 689	Continued From page 5 #1 said she was not surprised Resident #1 stood up by himself in the shower room. She said that was the only thing that could really scare you about Resident #1, "He would not call for help." You could be right there, and he would not ask for help." Nurse #1 explained Resident #1 fell a lot from getting up unassisted. She stated when she provided care for Resident #1, she always made sure she had him within arm's reach because he would just get up. A progress note dated 11/18/24 by the Assistant Director of Nursing (ADON) said Resident #1 had a fall in the shower room. The note said the shower team member reported Resident #1 stood on his own while she was turned to obtain supplies. He slipped and fell on the right hip. He had significant pain and could not move his right lower extremity. Provider in house (Medical Director) was notified and assessed Resident #1 and gave orders to send him to the emergency department (ED). An interview was conducted with the ADON on 12/12/24 at 4:42 PM. She recalled Resident #1 had a lot of falls in the past. She explained a lot of his falls were because he was very impulsive and would try to get up and do things for himself like go to the restroom. She said he tried to self-transfer at times and if the wheelchair was not positioned right, he would slide to the floor. The ADON stated she was present the day Resident #1 fell in the shower and said Nurse #1 had responded to the fall and had gotten her because Resident #1 was in a decent amount of pain. She explained Resident #1 told them he was in pain and was not able to straighten his right leg without calling out in pain. The ADON recalled when she went to the shower room,	F 689		

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Resident #1 was positioned on his back. She said she assessed Resident #1 and when he could not straighten his leg she got the Medical Director, who was in the facility to assess Resident #1. The ADON stated the Medical Director assessed Resident #1 and gave orders to send him to the ED for evaluation. The ADON said at the time of the incident she spoke with NA #1 about what happened. The ADON recalled NA #1 had said she brought Resident #1 into the shower room and set him up at the grab bar on the wall, removed his shoes, and asked him to take off his shirt, and then she turned and went to the linen cabinet to get wash cloths. The ADON said NA #1 had not told her how long she had been turned away from Resident #1. The ADON said she was not surprised Resident #1 had stood up by himself in shower and stated that was how most of his falls occurred. She explained during the investigation of the fall, Resident #1 not wearing appropriate footwear was identified as a potential factor for his fall. She said if NA #1 had set up supplies for Resident #1's shower ahead of time she would not have had to turn away from Resident #1 to get supplies from the cabinet. The ADON stated she did not know if NA #1 knew Resident #1 was impulsive and so she could not say if NA #1 should have turned her back on Resident #1 during the shower.

A progress note dated 11/18/24 by the Medical Director said Resident #1 was seen acutely due to a fall. The note indicated he was not able to straighten his leg. The note further said, Resident #1 had severe right hip pain post fall and stated, "will send to the emergency room for eval, strong suspicion he does have a fracture."

The hospital discharge summary dated 11/25/24

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said Resident #1 presented to the emergency department on 11/18/24 after an unwitnessed fall and was found to have a right femoral neck fracture. A surgical procedure to repair a femur fracture had been completed on 11/19/24 by the orthopedic surgeon. The note indicated there were no immediate complications noted. The note stated on 11/22/24 Resident #1 had experienced chest pain and shortness of breath. The note indicated a workup had been completed that was unremarkable and the symptoms self-resolved. The discharge summary said subsequently Resident #1 had waxing and waning of his mental status with some somnolence that did appear to be improving. The note further stated Resident #1 had experienced acute blood loss anemia suspected due to intraoperative blood losses and had required a blood transfusion of one unit of packed red blood cells. The note also indicated Resident #1 developed dysphagia (difficulty swallowing) and had difficulty swallowing pills on 11/20/24. The discharge summary revealed goals of care including hospice care had been discussed with the family during Resident #1's hospitalization. The discharge summary indicated Resident #1 had been discharged back to the facility on 11/25/24.

An interview was conducted with the Director of Nursing (DON) on 12/12/24 at 5:30 PM. The DON stated Resident #1 had fallen a lot because he had been impulsive at times. She said Resident #1 had been forgetful and thought he could do more than he could. She said most of his falls were from a combination of him being impulsive and getting up unassisted. The DON explained on 11/18/24 NA #1 had been assisting Resident #1 with his shower in the shower room. She

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F 689	Continued From page 8 recalled NA #1 reported she had taken off Resident #1's shoes and Resident #1was taking off his shirt. NA #1 had turned to put trash or linen in a bin close by and that was when Resident #1 had stood up and fell. The DON said she had assumed Resident #1 had stood up to remove his shirt and that was when he had fallen. The DON said Resident #1 had been in pain and the Medical Director had assessed him after the fall and gave orders to send Resident #1 to the ED. The DON was not aware NA #1 had walked to a linen cabinet/ shelf. The DON explained she thought NA #1 had placed something into the hamper or trash that had been right next to her. The DON thought Resident #1 having shoes or non-skid socks on may have prevented the fall. She also thought that if NA #1 did not turn her back when working with Resident #1 who was impulsive, it may have prevented his fall. She added he could still have stood up with NA #1 standing next to him and fell. The DON explained Resident #1 had been re-admitted to the facility on 11/25/24 from the hospital after the surgical repair of his hip. The DON said when Resident #1 re-admitted there was a big change in his status. She explained when he returned from the hospital he was not eating and never got out of bed. The DON stated Resident #1 had been admitted to hospice on 11/27/24, continued to decline and passed away at the facility on 12/3/24. The DON said she could not answer if Resident #1's fall contributed to his death and was unaware of what the Medical Examiner had found regarding the cause of Resident #1's death. A telephone interview was conducted with the Medical Director (MD) on 12/12/24 at 4:57 PM. He stated he vaguely remembered the incident and did not remember specifics about the fall or	F 689		

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assessment. The MD said he did not know the situation well enough to say if Resident #1's fall contributed to his death. He said he had not been there to see the fall so it was hard to say if it could have been prevented and he was not familiar enough with Resident #1 to say. He stated the fall could have contributed to Resident #1's death because it was an injury and trauma, but that it was not the cause of his decline. He said it sounded like Resident #1 had other ongoing issues that led to his decline and death.

A telephone interview was conducted with the Medical Examiner (ME) on 12/12/24 at 5:08 PM. The ME stated he conducted the medical exam for Resident #1 on 12/3/24 when Resident #1 passed away. He recalled Resident #1 had a fall with a right femoral neck fracture. The ME stated he had attributed Resident #1's death to complications from his fall on 11/18/24 because Resident #1 had never returned to his baseline before his death. The ME stated he had determined the fall had contributed to Resident #1's death.

An interview was conducted with the Administrator on 12/12/24 at 6:17 PM. The Administrator stated Resident #1 had a history of falls and he recalled Resident #1's fall on 11/18/24. He said he was aware Resident #1's fall had occurred in the shower room when NA #1 turned her back for a moment and he stood up and fell. The Administrator said he was not sure if Resident #1's fall could have been prevented. He said it was Resident #1's behavior and pattern to get up unassisted and not call for help. The Administrator confirmed Resident #1 had been readmitted to the facility on 11/25/24 after the hospitalization for the surgical repair of his hip.

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F 689	Continued From page 10 He said when Resident #1 was readmitted to the facility he had a status change. He described the status change as failure to thrive and said Resident #1 had been admitted to hospice. The Administrator said he was not aware of the ME findings regarding Resident #1's cause of death. The facility's Administrator was informed of the immediate jeopardy on 12/13/24 at 11:59 AM. The facility submitted the following credible allegation of immediate jeopardy removal. 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The jeopardous alleged deficient practice resulted when it is alleged the facility failed to ensure that Resident #1was supervised during a shower. On November 18, 2024 Nurse Aide (NA) #1 had Resident #1 in the shower room in his wheelchair. Resident #1 had removed his shoes, had on his socks, and was removing his shirt when NA #1 stepped away from Resident #1 to go to a linen cabinet that was approximately 8-10 feet away. When NA #1 turned back around Resident #1 was standing up from his wheelchair, lost his balance and fell. Resident #1 was assessed by the Nurse and Medical Doctor (MD) and send sent to the Emergency Department on November 18, 2024. He was noted to have a right unspecified femoral neck fracture that required surgical repair. Resident #1 returned to the facility on November 25, 2024, and passed away on December 3, 2024.	F 689		

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Nurse Aide #1 (a member of the facility shower team) was educated by the Director of Nursing (DON) on November 21, 2024, on ensuring that she does not turn away from the resident in the shower room while performing showering and bathing tasks.

A 100% review of all falls occurring in the last 60 days was conducted by the DON and Assistant Director of Nursing (ADON) on November 27, 2024, to ensure there were no repeated patterns related to falls in the shower room. There were no other concerns identified relating to this isolated incident. No additional opportunities for staff education were identified as a result of this review.

All residents identified as being at risk for falls will have care plan reviews conducted by the DON and ADON on December 14, 2024, to ensure that fall interventions are appropriate related to assistive devices and level of supervision.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

A root cause analysis was conducted by the DON and ADON on November 26, 2024. The root cause was determined to be that Nurse Aide #1 removed Resident #1's shoes prior to transferring to the shower chair and turned her back to throw away trash. An ad hoc QAPI meeting was held on November 27, 2024, to review the root cause analysis and approve the proposed plan of correction.

All nurse aides on the facility shower team were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING ______ B. WING ______	C 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD 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 689	Continued From page 12 educated by the DON as of December 4, 2024, on ensuring that staff do not turn away from the resident in the shower room while performing showering and bathing tasks. All facility nurse aides and licensed nurses were educated by the DON as of December 12, 2024 on ensuring that staff do not turn away from the resident in the shower room while performing showering and bathing tasks. All facility nurse aides and licensed nurses will be educated in-person by the Administrator or DON or trained designee on the facility fall management policy with an emphasis on ensuring assistive devices are in place and adequate supervision provided to prevent falls. This education will focus on common risk factors for falls including environmental, transfer/mobility status, and equipment, as well as staff interventions to mitigate these risk factors. In this education the root causes of improper footwear and not turning away from a resident during care will be reviewed not only for the shower room but as a risk factor throughout the facility. This in-person education will be completed no later than December 14, 2024. Any facility nurse aide or licensed nurse that does not receive the education by this date will not be allowed to work until the education is received by the Administrator or DON. The Administrator will be responsible for ensuring that education is completed by December 14, 2024. The Administrator will be responsible for ensuring that any nurse aide or licensed nurse that does not receive the education by this date will not be allowed to work until the education is received. Any newly hired nurse aide or licensed nurse after 12/14/24 will receive the education prior to	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING ______ B. WING ______	C 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF HENDERSONVILLE	**290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792**

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F 689	Continued From page 13	F 689		

working their first shift on the floor and the Administrator will be responsible for ensuring this action.

The facility alleges the immediate jeopardy was removed on 12/15/24. The Administrator is responsible to implement the plan.

On 12/17/24 the facility's credible allegation of immediate jeopardy removal was validated by the following:

The immediate jeopardy removal plan was validated on 12/17/24 and verified the facility implemented an acceptable immediate jeopardy removal plan on 12/14/24 as evidenced by facility documentation and staff and resident interviews. Review of the in-service sign-in sheets dated 11/27/24, 12/6/24, and 12/14/24 revealed all Nurses, Nurse Aides, and Medication Aides received education on transfers, shower footwear, and fall management with transfers. Sampled residents' care plans were up to date for fall risk with no concerns noted. Interviews with facility staff revealed they received the in-service education regarding the facility's transfer/ shower protocol and fall management with transfer policy.

The immediate jeopardy removal date of 12/15/24 was validated.