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 _____	03/20/2025

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
E 000	Initial Comments An unannounced recertification survey was conducted from 3/17/25 through 3/20/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 274J11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted from 3/17/25 through 3/20/25. Event ID # 274J11.	F 000		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		3/29/25

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

Electronically Signed | 04/03/2025

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.

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 _____	03/20/2025

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 732	Continued From page 1 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a daily nurse staffing sheet for 50 of 76 days for the period reviewed from January 1, 2025 through March 17, 2025. The findings included: A review of the daily nurse staffing sheets for January 1, 2025 to January 31, 2025 revealed no information for 1/01/2025, 1/02/2025, 1/03/2025, 1/04/2025, 1/05/2025, 1/06/2025, 1/08/2025, 1/09/2025, 1/10/2025, 1/11/2025, 1/12/2025, 1/18/2025, 1/19/2025, 1/22/2025, 1/25/2025, 1/26/2025, and 1/28/2025. A review of the daily nurse staffing sheets for February 1, 2025 to February 28, 2025 revealed no information for 2/01/2025, 2/02/2025, 2/03/2025, 2/05/2025, 2/08/2025, 2/09/2025, 2/10/2025, 2/11/2025, 2/12/2025, 2/13/2025, 2/15/2025, 2/16/2025, 2/20/2025, 2/21/2025, 2/22/2025, 2/23/2025, 2/24/2025, 2/25/2025, 2/27/2025 and 2/28/2025. A review of the daily nurse staffing sheets for	F 732	1. The facility will continue to display accurate Posted Nursing Staffing Information daily. The Administrator verified that Posted Nursing Staffing Information was displayed on 3.20.25, the date of discovery. No negative outcome was identified relating to this observation. 2. Subsequent Posted Nursing Staffing Information after 3.20.25 has the potential to be affected. Posted Nursing Staffing Information from 3.21.25 – 3.26.25 was reviewed on 3.26.25 by the Administrator to ensure that accurate Posted Nursing Staffing Information was displayed daily. No negative outcome was identified relating to these observations. 3. The DON, Scheduling Coordinator, Medical Records clerk, and Licensed Nurses were inserviced by the Administrator as of 3.28.25.25 on the	

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 _____	03/20/2025

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 732	Continued From page 2 March 1, 2025 to March 17, 2025 revealed no information for 3/01/2025, 3/02/2025, 3/04/2025, 3/05/2025, 3/06/2025, 3/07/2025, 3/08/2025, 3/09/2025, 3/10/2025, 3/11/2025, 3/14/2025, 3/15/2025 and 3/16/2025. An interview on 3/20/25 at 1:26 PM with the Medical Records Clerk #1, revealed the daily nurse staffing sheet was her responsibility to complete each morning. She completed each section for day, evening and night shift based on the staffing information she was given by nursing and posted the information at the front reception desk. She pulled the old sheet and placed it in the binder which was kept in the medical records office. She stated some dates were missing completed sheets and she did not know who completed this task if she was not working. A follow up interview on 3/20/25 at 1:34 PM with the Medical Records Clerk #1, revealed she talked with the Administrator and there was not a plan in place for another staff member to complete the daily nurse staffing sheet when she (Medical Records Clerk #1) was not working. An interview on 3/20/25 at 1:48 PM with the Director of Nursing (DON) revealed no one had been completing the nurse staffing sheet when Medical Records Clerk #1 was not working. An interview on 3/20/25 at 2:02 PM with the Administrator revealed the nurse staffing sheet was to be completed daily. He was not aware the nurse staffing sheet was not completed the days Medical Records Clerk #1 was not working.	F 732	facility policy for ensuring that accurate Posted Nursing Staffing Information is displayed daily. The education emphasized that the DON/designee will be assigned by the Administrator to complete this task when the Medical Records clerk is off duty. Any staff not receiving the education by 3.28.25 and any newly hired staff after 3.28.25 will receive the same education prior to working their first shift. 4. A QA monitoring tool will be utilized to ensure ongoing compliance by the Administrator/designee beginning on 3.29.25. The Administrator/designee will review Posted Nursing Staffing Information 5x/week x 4 weeks then 3x/week x 4 weeks then weekly x 4 weeks to ensure that accurate Posted Nursing Staffing Information is displayed. Variances will be corrected at the time of audit and additional education provided when indicated. 5. Beginning after 3.29.25, the audit results will be reviewed by the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved	

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 _____	03/20/2025

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 732	Continued From page 3	F 732	and additional education/training will be provided for any issues identified. 6. Date of compliance: 3.29.25	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep dumpster doors and lids closed for 2 of 3 dumpsters observed and have a lid on one plastic garbage can and maintain another plastic garbage can in good condition for 2 of 2 garbage cans observed. The findings included: A continuous observation of the dumpster area was conducted on 3/18/25 from 2:49 PM to 3:05 PM. On the right side of the dumpsters were two wheeled gray plastic garbage cans. One gray garbage can had no lid and was half full of loose refuse and the other gray garbage can holding rock salt was lidded with a grapefruit sized hole three-quarters of the way up the side of the can. One of the two large dumpsters had both lids open, and the small dumpster had one of two lids open and a side door open. The Dietary Manager, Maintenance Director and Maintenance Assistant were present during this observation. An interview with the Dietary Manager on 3/18/25 at 2:50 PM revealed she was not aware the dietary department was responsible for maintaining the dumpster area. She indicated the	F 814	1. The facility will continue to ensure that dumpster doors and lids are kept closed and maintained in good condition. The plastic garbage cans were discarded at the time of discovery. The dumpster doors and lids were closed at the time of discovery. No negative outcome was identified relating to this observation. 2. There is only one dumpster area on the facility property. 3. The Administrator contacted the waste management company contracted with the facility on 3.25.25 to obtain quotes on Gravity Locking Containers to prevent dumpster doors from blowing open due to wind. All staff were inserviced by the Administrator on the expectation that trash will be disposed of inside the dumpster and that the lids/doors are to remain closed when not in use. This education was completed by 3.28.25. Any staff not receiving the education by	3/29/25

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 _____	03/20/2025

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 814	Continued From page 4 dumpster area should be free of debris and lids closed for pest control as the dumpsters were close to the kitchen. The Dietary Manager revealed she would monitor the dumpster area on a regular basis now. An interview with the Maintenance Director on 3/18/25 at 2:56 PM revealed the waste management company emptied the dumpsters on Mondays, Wednesdays and Fridays. The Maintenance Director stated the lids and doors of the dumpsters and plastic garbage cans should be closed for pest control. On 3/19/25 at 9:01 AM an observation of the dumpster area revealed the rolling garbage cans observed on 3/18/25 had been removed and the small dumpster was observed to have one of two lids open. During an interview with the Administrator on 3/19/25 at 3:30 PM he revealed the maintenance department was responsible for maintaining the dumpster area. He indicated the dumpster area should be kept clean for pest control and the dumpster lids and doors closed.	F 814	3.28.25 and any newly hired staff after 3.28.25 will not be allowed to work until receiving the education. 4. A QA monitoring tool will be utilized by the Administrator/designee beginning on 3.29.25 to ensure that trash is disposed of inside the dumpster and the lids/doors are closed when not in use. The Administrator/designee will randomly observe dumpster area 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then bi-weekly x 4 weeks to ensure that trash is disposed of inside the dumpster and the lids/doors are closed when not in use. Variances will be corrected at the time of observation and additional education provided when indicated. 5. Observation results will be reviewed by the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. 6. Date of compliance: 3.29.25	