

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER The Greens at Hendersonville		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 Pisgah Drive Hendersonville, NC 28791	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037</p> <p>Based on record review and staff and Physician interviews the facility failed to provide incontinence care in a safe manner for 1 of 3 residents reviewed for accidents (Resident #3).</p> <p>Findings included:</p> <p>Resident #3 was admitted to the facility 07/01/09 with diagnoses including stroke, hemiplegia (paralysis of one side of the body), repeated falls, and aphasia (a language disorder that affects a person's ability to communicate).</p> <p>Review of Resident #3's Physician orders revealed an order dated 05/03/22 for clopidogrel (an anti-platelet medication) 75 milligrams (mg) once a day for cerebral infarction (stroke) due to unspecified occlusion of cerebral (brain) artery.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was moderately cognitively impaired, required partial to moderate assistance with rolling from side to side in bed, had impaired range of motion on one side of his upper and lower extremities, and was always incontinent of bowel and bladder.</p> <p>A telephone interview with Nurse Aide (NA) #1 on 06/19/24 at 3:10 PM revealed she was caring for Resident #3 when he fell out of bed the morning of 03/27/24. She stated she provided incontinence care for Resident #3 and was changing his bottom sheet when he fell out of bed. NA #1 explained she used the bed pad to turn Resident #3 away from her so she could place the clean bed sheet underneath him and he was using his unaffected arm to hold onto a dresser beside his bed. NA #1 stated Resident #3 let go of the dresser and fell face first onto the floor. She stated Resident #3 hit his head on the dresser as he fell and began bleeding from his head. NA #1 stated she immediately notified Resident #3's nurse of his fall and the nurse assessed him right away. She stated after Resident #3's nurse assessed him; she and the nurse assisted him back to bed. NA #3 stated she had only been employed at the facility for a couple of months at the time of Resident #3's fall and she had been trained by other NAs that he only required one person assist for incontinence care and linen changes. She stated she had been trained by facility staff to roll him away from her when providing care, even with no side rails or another staff member present to assist with care.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nurse's note written by Nurse #3 and dated 03/27/24 at 5:34 AM is as follows: During rounds resident was turned and repositioned for care and fell out of the bed with 'certified nursing assistant' (CNA) present. Resident has a bruise on the left side of his head above the eyebrow, skin tear on the left knee, left elbow, second and third knuckle on the right hand. No present complaints of pain, no signs indicating resident is in discomfort. Resident was observed on his back when this writer entered the room. Vitals collected. Lacerations cleaned and dressed.</p> <p>Nurse #3 was unavailable for interview during the survey.</p> <p>Hospital records dated 03/27/24 documented Resident #3 was seen in the Emergency Department (ED) for a fall, facial laceration, and contusion of face at 10:21 AM. The note documented Resident #3 had bruising around his left eye, a laceration above his left eyebrow, and a skin tear to the left elbow and knee. A CT scan (detailed x-ray) dated 3/27/24 documented Resident #3 had no cervical spine (neck) fractures (broken bones), no facial fractures, and no intracranial (inside the skull) abnormality, but had a left forehead hematoma (bruise) with laceration. The note documented Resident #3's facial laceration did not require sutures (stitches) and was closed with tissue adhesive. The note documented Resident #3 was stable and was discharged back to the facility on [DATE] at 2:43 PM.</p> <p>An interview with the Director of Nursing (DON) on 06/20/24 at 3:38 PM revealed all falls were discussed in the morning meeting. She stated Resident #3's fall on 03/27/24 was discussed in the morning meeting and Physical Therapy (PT) was going to evaluate him, his mattress was changed to a bolster mattress (a mattress with built-in bolsters that define the edges of the bed and helps prevent falls), and a halo bed rail (small, round upper handrail to aid with bed mobility) was added to his bed. The DON stated residents with hemiplegia should be turned toward staff when providing care and she educated NA #3 with that information via telephone.</p> <p>In a follow-up telephone interview with NA #3 on 06/19/24 she confirmed she received education on 03/27/24 by the DON to turn Resident #3 toward her in the future when providing his care due to hemiplegia.</p> <p>A telephone interview with Physician #1 on 06/20/24 at 10:32 AM revealed he was asked to assess Resident #3 after his fall the morning of 03/27/24. Physician #1 stated that he gave orders to send Resident #3 to the hospital for evaluation because when he assessed Resident #3, he was moaning, and he felt the laceration above his eyebrow required more than adhesive tape strips to allow the wound to heal. He stated he did not feel the delay between the time Resident #3 fell and the time he was sent to the hospital on 03/27/24 caused Resident #3 any harm.</p> <p>An interview with the Administrator on 06/21/24 at 10:31 AM revealed she felt Resident #3 had not been eating well prior to his fall and that probably caused him to be weaker and his fall was just an unforeseen accident.</p>		