

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER The Laurels of Hendersonville		STREET ADDRESS, CITY, STATE, ZIP CODE 290 Clear Creek Road Hendersonville, NC 28792	
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)		

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews with the Pharmacist Consultant and staff, the facility failed to have effective systems in place for returning controlled narcotic medications (oxycodone-acetaminophen) to the pharmacy after a resident was discharged. The oxycodone-acetaminophen continued to be stored in the medication cart after the resident's discharge and during the monthly reconciliation of controlled substances misappropriation was identified. This occurred for 1 of 3 residents reviewed for pharmacy services (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with diagnosis including dementia and calculus of the kidney (kidney stone). The 5-day admission Minimum Data Set (MDS) dated [DATE] revealed Resident #1's cognition was moderately impaired, opioid medication was taken, and scheduled pain medication was received during the lookback period. Resident #1's physician orders included oxycodone-acetaminophen 5-325 milligram (mg) tablet give one tablet every six hours as needed for severe pain started on 8/12/25. The medication was discontinued on 8/26/25. Resident #1 was discharged from the facility to the community on 8/25/25. A review of the pharmacy proof of delivery records revealed on 8/13/25 Resident #1 received one blister card with 12 tablets of oxycodone-acetaminophen 5-325 mg and on 8/15/25 one blister card with 30 tablets. A review of the Resident #1's oxycodone-acetaminophen 5-325 mg declining count sheet for 12 tablets received on 8/13/25 indicated it was copy made on 8/29/25. The declining count sheet revealed nurses signed out one tablet on 8/14/25 at 11:19 AM, one tablet on 8/16/25 at 5:02 PM, one tablet on 8/21/25 at 10:00 PM and two tablets on 8/24/25 at 12:49 AM and 11:36 PM. The declining count sheet indicated seven tablets remained in the blister card. A review of a second copy of Resident #1's oxycodone-acetaminophen 5-325 mg declining count sheet for 12 tablets indicated the copy was made on 8/30/25. The second copy included an additional entry made by Nurse #2. Nurse #2's signature was added to indicate she removed one tablet on 8/25/25 at 6:02 AM and six tablets remained in the blister card. A review of the Resident #1's oxycodone-acetaminophen 5-325 mg declining count sheet for the 30 tablets received on 8/15/25 had none signed out to indicate 30 tablets remained in the blister card. A review of Resident #1's Medication Administration Record (MAR) revealed one tablet of oxycodone-acetaminophen 5-325 mg was administered as follows: 8/13/25 at 11:30 AM, 8/14/25 at 11:19 AM, 8/15/25 at 10:39 AM and at 9:28 PM, 8/16/25 at 5:02 PM, 8/21/25 at 10:08 PM, 8/22/25 at 10:42 PM, 8/24/25 at 12:49 AM and at 11:36 PM. The MAR indicated nine tablets of oxycodone-acetaminophen 5-325 mg tablets were administered. The initial 24-hour allegation report completed by the Administrator revealed the facility became aware on 8/30/25 at 5:15 PM of a drug diversion incident and notified law enforcement at 6:17 PM and the state survey agency at 6:47 PM. Details of the allegation revealed one blister card of oxycodone-acetaminophen and its declining count sheet were missing from the 400 Hall medication cart. The allegation revealed Nurse #1 and Nurse #2 were assigned to the 400 Hall medication cart when the oxycodone-acetaminophen was identified as missing and suspended pending a drug test and investigation. The 5-day investigation report dated 9/5/25 revealed the facility confirmed the blister card with 30 doses of oxycodone-acetaminophen 5-325 mg was missing and Nurse #1 was terminated. The facility's corrective action revealed nurses and Medication Aides were educated on the controlled substance policy and handling process for narcotic medications and they would complete a focused audit on reconciling newly added and removed narcotic medications from the medication cart. During an interview on 9/9/25 at 1:22 PM and 3:23 PM the Director of Nursing (DON) stated on 8/29/25 as part of her monthly routine review she checked the facility's medication carts and all the controlled substances and declining count sheets were accounted for, and the counts were correct including Resident #1's oxycodone-acetaminophen 5-325 mg. The DON stated she made copies of the declining count sheets on 8/29/25 to check physician orders and ensure each controlled medication stored on the carts had an active physician's order and if not she planned to remove it and return to the pharmacy. The DON stated after reviewing the physician orders, she discovered Resident #1 was discharged on 8/25/25 and did not have an active order for oxycodone-acetaminophen and on 8/30/25 she gave copies of the declining count sheets and asked the Unit Manager to remove both blister cards from the 400 Hall medication cart. The DON stated after the 400 Hall medication cart was checked by the Unit Manager, she was informed Resident #1's oxycodone-acetaminophen 5-325 mg blister card containing 30 tablets and the declining count sheet were missing. The DON stated it was approximately 4:00 PM on 8/30/25 when the Unit Manager informed her of the missing oxycodone-acetaminophen 5-325 mg</p>		