

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345493	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Hendersonville Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 104 College Drive Flat Rock, NC 28731	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037</p> <p>Based on observations, record review, and staff interviews the facility failed to assess the ability of a resident to self-administer medication for 1 of 1 resident with medication observed in the room (Resident #84).</p> <p>Findings included:</p> <p>Resident #84 was admitted to the facility 08/07/24.</p> <p>Review of the medical record revealed no documentation that Resident #84 was assessed for self-administration of medications.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #84 was moderately cognitively impaired.</p> <p>Review of Resident #84's physician orders revealed no current order for the use of an anti-fungal medication.</p> <p>Observations of Resident #84's overbed table on 09/09/24 at 9:35 AM, 09/10/24 at 3:36 PM, and 09/11/24 at 11:20 AM revealed a 3 milliliter (ml) medication pen with the active ingredient tolnaftate (antifungal medication) 1% lying on top of the table.</p> <p>An interview with Resident #84 on 09/09/24 at 9:35 AM revealed he usually applied the anti-fungal medication daily to treat fingernail fungus.</p> <p>An observation of Resident #84's fingernails on both hands on 09/09/24 at 9:35 AM revealed his fingernails had a yellowish discoloration with a ripple-like texture.</p> <p>In an interview with the Director of Nursing (DON) on 09/11/24 at 1:05 PM she confirmed the anti-fungal medication pen would be considered a medication and should not be left on Resident #84's overbed table. She stated staff rounded on resident rooms daily to check for medications left in resident rooms and that it was overlooked.</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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A follow-up interview with the DON on 09/11/24 at 2:20 PM revealed if a resident wanted to self-administer medication they had to be assessed as safe to self-administer medication, a physician order was obtained, and the medication would be stored in the locked top drawer of the resident's dresser. The DON confirmed Resident #84 had not been assessed to self-administer medication.</p> <p>An interview with the Administrator on 09/11/24 at 2:38 PM revealed medications should not be left in a resident's room without a physician order. He stated staff rounded on resident rooms daily to check for medications left in the room and he felt the anti-fungal pen was overlooked because it looked similar to a writing pen.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538</p> <p>Based on observations and interviews with staff, the facility failed discard expired leftover food ready for use in 1 of 1 walk-in cooler and failed to ensure the floor in the dry food storage area was clean in 1 of 1 kitchen. These practices had the potential to affect food served to residents.</p> <p>Findings included:</p> <p>a. During a walk-through observation of the kitchen and interview with the Assistant Dietary Manager (DM) on [DATE] at 8:52 AM through 9:45 AM revealed a 12-ounce package of sliced bologna with an expiration date of [DATE] being stored in the walk-in cooler ready for use with no resident name or or date on the package. The Assistant DM revealed she removed the bologna from freezer on [DATE] so it could thaw for a resident who had requested it and forgot to label and date the package when it was removed.</p> <p>b. An observation and interview conducted with the DM on [DATE] at 9:45 AM revealed the tile floor in the dry food storage area had crumb-like debris scattered underneath the metal shelving where food was being stored. A wrapped nutrition bar and can of soda was left on the floor underneath the shelving. The tile baseboard and floor underneath the metal shelving by the wall throughout the dry food storage area appeared dirty with thick black colored buildup of debris. The DM revealed the Dietary Aides swept and mopped the floors in the dry storage area daily. She observed the floors throughout the dry storage area underneath the metal shelving were dirty with a thick black colored buildup of debris and revealed Dietary Aide staff probably had a hard time reaching that area of the floor due to the metal shelving was attached to the wall making it difficult to reach.</p> <p>During an interview on [DATE] at 1:18 PM Dietary Aide #1 confirmed she worked and was the person who swept and mopped the floor in the dry food storage area by the end of her shift on [DATE]. Dietary Aide #1 revealed she had scrubbed the area and was able to reach underneath the metal shelving and to her the floor appeared clean. She revealed she did not observe a thick buildup of black colored debris on the tile floor.</p> <p>During an interview on [DATE] at 2:32 PM the Administrator revealed the bologna was requested by one resident and not in use of all residents. The Administrator revealed he wanted Dietary staff to do their best to keep the kitchen clean.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014</p> <p>Based on observation, staff interviews, and resident interview, the facility failed to ensure a call light was functioning properly for 1 of 1 resident who required staff assistance for activities of daily living (Resident #80).</p> <p>The findings included:</p> <p>Resident #80 was admitted to the facility on [DATE].</p> <p>The annual Minimum Data Set assessment dated [DATE] revealed Resident #80 had intact cognition.</p> <p>An observation and interview was conducted with Resident #80 on 09/08/24 at 11:38 AM. Resident #80 was lying in bed trying to get a hold of the pancake call light (round and flat that activates when touched) that was attached to the bed sheet and was hanging off the right side of the bed. Resident #80 stated she was wanting to sit up on the side of the bed and needed staff assistance. When Resident #80 attempted to press the call light, the light on the wall panel in her room and the light over her doorway in the hall did not activate. Nurse Aide (NA) #1 was notified Resident #80 was needing staff assistance and proceeded into Resident #80's room.</p> <p>A subsequent observation of the call light in Resident #80's room was conducted on 09/08/24 at 3:15 PM. Resident #80 was lying in bed, sleeping soundly, with the call light on the bed directly beside her. When the call light was pressed, the light on the wall panel in her room and the light over her doorway in the hall did not activate. Also, the call light for the empty bed that was in Resident #80's room was checked and the light on the wall panel and over the doorway did not activate.</p> <p>During an interview on 09/10/24 at 9:56 AM, NA #1 confirmed she was assigned to provide care to Resident #80 during first shift on 09/08/24 and was not aware that Resident #80's call light was not functioning. NA #1 explained she was in and out of Resident #80's room frequently on 09/08/24 and Resident #80 had not voiced any concerns to her about the call light. NA #1 stated typically when a call light was malfunctioning, there was an indicator on the light above the doorway and maintenance would be notified but she had not noticed anything.</p> <p>An observation and interview was conducted with the Weekend Nurse Supervisor on 09/08/24 at 3:15 PM. The Weekend Nurse Supervisor confirmed the light on the wall panel in the room or over the doorway did not activate when Resident #80's call light or the call light for the empty bed in the room were pressed. She was unaware the call lights were not working in Resident #80's room. She stated Resident #80 could use her call light for assistance and if they had known her call light was not working, they could have given Resident #80 a hand bell to use until the call light was repaired. She stated the Maintenance Director was in the facility today and she would notify him of the issue.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation and interview was conducted with the Maintenance Director on 09/08/24 at 3:25 PM. The Maintenance Director confirmed the light on the wall panel in the room or over the doorway did not activate when Resident #80's call light or the call light for the empty bed in the room were pressed. The Maintenance Director explained when repairs were needed, typically nursing staff would enter a work order in the computer system or notify him verbally. The Maintenance Director stated he was unaware the call lights were not working in Resident #80's room and he had not received any work order or verbal notification from nursing staff.</p> <p>During a follow-up observation and interview on 09/09/24 at 9:32 AM, Resident #80 stated using her call light was a joke because she would push the call light when assistance was needed but it would take staff over a half an hour to respond during the day time, if at all, and at night, no one would respond. An observation of Resident #80's call light revealed when the call light was pushed, the light on the wall panel in her room and the light over the doorway in the hall both activated.</p> <p>During a follow-up interview on 09/10/24 at 3:52 PM, the Maintenance Director revealed he had been in his current position for 3 months. He stated he made daily rounds of resident rooms to check the water temperature and also checked to see if the call lights were functioning properly. The Maintenance Director explained he did not document his daily rounds or the rooms he checked if there were no issues identified and only documented if repairs were made. He could not recall the last time Resident #80's call light was checked for functioning.</p> <p>During an interview on 09/10/24 at 3:58 PM, the Administrator stated administrative staff members had assigned rooms for them to make daily rounds. During the daily rounds, he explained they used a checklist to guide observations and note any identified concerns which included checking the call lights to ensure they were working but they did not keep the checklists of the daily rounds that were completed. The Administrator stated Resident #80 was someone who used her call light frequently and he would have assumed that nursing staff would have noticed her call light was not working on 09/08/24 and put a work order into the facility system for maintenance to repair.</p>		