

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT Is not met as evidenced by: Based on observations, physician interview, pharmacist interview, staff interviews and record reviews facility staff failed to get a clarification order from a physician for a multivitamin and failed to administer a nutritional supplement as ordered in one (1) of sixteen (16) residents observed during medication pass. (Resident #196). The facility also failed to ensure a test for occult blood in stool was done for one (1) of one (1) sampled residents. (Resident #105)</p> <p>The findings are:</p> <p>Resident #196 was admitted with diagnoses including high blood pressure, anemia, heart disease and end stage kidney disease.</p> <p>The most recent admission Minimum Data Set (MDS) dated 7/27/12 indicated Resident #196 had no impairment in short and long term memory and no impairment in cognition for daily decision making. The MDS also indicated Resident #196 required extensive assistance from staff for activities of daily living and was frequently incontinent of bladder and bowel. The MDS titled "Section O" indicated Resident #196 received dialysis care.</p> <p>A review of a document titled "Mission Hospital Clinical Discharge Summary" dated 7/20/12</p>	F 281	<p><u>Corrective Action for the Resident Found with Deficient Practice:</u></p> <p>The family and physician was notified and the orders for multivitamin and nutritional supplement were clarified, corrected on Medication Administration Record (MAR) and the correct medications were placed in the medication cart for Resident #196 on 08/02/12. Physician's clarification order to D/C multivitamin (Nephro-Vite) one po daily and start MVI one tab po daily.</p> <p>The family and physician was notified for orders to retest for occult blood in stool of resident #105. Per physician's order, facility did obtain a sample for occult blood in stool test on 08/16/12 from resident #105. Resident was discharged to the hospital on 08/20/12 and readmitted to the facility on 08/23/12 with no physician's order for occult blood in stool test.</p> <p><u>Corrective Action for Having Potential for Same Deficient Practice:</u> All residents have been identified as having potential to be affected by this practice.</p> <p>Audits to confirm medication orders were done and properly documented by utilizing a "Physician Order Audit" on 08/03/12 and were verified to be in 100% compliance.</p> <p>Audits to confirm laboratory orders were done and properly documented by utilizing a "Laboratory Tracking Audit" on 08/03/12 and were verified to be in 100% compliance.</p>	8/31/12

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Mehville Morrow

TITLE

Administrator

(X6) DATE

8.29.12

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.

RECEIVED
SEP 5 2012
BY: DRW

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 281	<p>Continued From page 1</p> <p>indicated to give a Multi-Vitamin (Nephro-Vite) one (1) tablet by mouth daily and give Nepro (a therapeutic nutritional supplement specifically designed to meet the needs and altered metabolism of patients on dialysis) one (1) can by mouth twice a day.</p> <p>A review of hand written physician's orders dated 7/20/12 through 7/31/12 indicated a Multivitamin (Nephro-Vite) one (1) by mouth daily to be given at 8:00 AM and Nepro one (1) can by mouth twice daily at 9:00 AM and 9:00 PM.</p> <p>A review of a hand written monthly Medication Administration Record (MAR) dated 7/20/12 through 7/31/12 indicated Multivitamin (Nephro-Vite) one (1) tablet by mouth daily as a supplement and Nepro one (1) can twice daily (in refrigerator Day Room) at 9:00 AM and 9:00 PM. The MAR further indicated the Nepro was circled each day at 9:00 AM and 9:00 PM from 7/20/12 through the morning of 7/25/12.</p> <p>A review of a facility document titled "Diet Order and Communication" dated 7/20/12 indicated Resident #196 was on a renal diet and Nepro one (1) can twice daily.</p> <p>A review of a facility document titled "Purchase Order Confirmation" with an order date of 7/23/12 indicated twenty-four, eight (8) ounce cans of Nepro was ordered from a distributor.</p> <p>A handwritten note on the back of the MAR dated 7/23/12 at 9:00 PM indicated for Nepro "we do not offer this brand but have told resident they can provide own."</p>	F 281	<p><u>Measures Put Into Place or Systemic Changes to Ensure Deficient Practice Does Not Reoccur:</u></p> <p>Facility nurses have received education on the facility's "Physician Orders" policy and procedure. Effective 08/02/12, physician orders require the signature or initial of two (2) nurses on the Physician Order, MAR and/or lab book. The nurse taking off the order is to record the order on the MAR and/or lab book and initial, and the night shift nurse will review physician orders for the day on all charts responsible for, verify the order was taken off and documented, make any corrections as needed, then initial the MAR and/or lab book. Facility nurses received in-service education on the facility's medication administration policies including "Medication Storage and Security in the Facility" which details the receipt of medications from the pharmacy, upon which a nurse signs the pharmacy delivery slip, confirming that the tote (or transport container) was received from the driver. The nurse opens the tote and reconciles the manifest with the line item listing and the medication requests. The driver does not have to wait for the reconciliation. Should there be a discrepancy, the pharmacy is called immediately. Once the nurse has satisfied the delivery contents for all medications other than control medications, the medications are either placed in the locked medication cart for the specified resident(s) or placed in the locked medication room for the receiving nurse to place in the medication cart as soon as possible or for the next immediate oncoming shift to place in the medication cart. Discontinued</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 281	<p>Continued From page 2</p> <p>A review of the computer generated monthly physician's orders from the pharmacy and dated 8/1/12 through 8/31/12 indicated Rena-Vite 0.8 mg. by mouth one (1) tab daily at 8:00 AM and Nepro was not listed on the physician's orders.</p> <p>A review of a typed monthly MAR dated 8/1/12 through 8/31/12 indicated Rena-Vite 0.8 mg. by mouth at 8:00 AM and Nepro was not listed on the MAR.</p> <p>A review of a handwritten note from a dialysis center dated 8/2/12 indicated the health focus for Resident #196 was on increasing dietary protein intake to remove swelling and stop "weeping" of the skin in her legs. "Please give Nepro daily as a nutritional supplement."</p> <p>During observations of medication pass on 8/2/12 at 9:00 AM licensed nurse (LN) #5 looked for Rena-Vite 0.8 mg. in the medication cart and medication room but could not find it and walked back to the medication cart and continued with her medication pass.</p> <p>During an interview with LN #5 on 8/2/12 at 2:36 PM she explained she asked for clarification about the Rena-Vite and was told the nursing staff had been giving Resident #196 a generic multivitamin from the stock supply each day beginning on 7/20/12. LN # 5 stated there was no documentation in the medical record that nursing staff had called the physician for clarification of the order for Rena-Vite until this morning when she questioned where the medication was kept. She stated she did not know anything about the Nepro or who supplied it and she had not given it to Resident #196. LN # 5 verified the circles on</p>	F 281	<p>medications are removed from the medication cart when a physician's order is received to discontinue. If a delivered medication is replacing another and the medication that was discontinued has not been removed from the medication cart, then the discontinued medication is removed when the new medication is placed in the medication cart. On a monthly basis at the end of every month, medications are reconciled as part of the ongoing monthly updating of physician orders. "Physician Order Transcription" policies which include utilizing the "Laboratory Tracking Form" 08/02/12 through 08/28/12. Medication administration policies and procedures will be provided to newly hired licensed nursing personnel during the 40-hour orientation period. All licensed nursing staff will be in-serviced on medication administration at least annually. Newly hired licensed staff will have documented competencies within 30 days of hire.</p> <p>Monitoring</p> <p>1.The facility's ADON and SDC and the contracting pharmacy (OmniCare) will provide "MedPass" audits (medication Administration/skills proficiency reviews for facility nurses on a monthly basis.</p> <p>2.Every facility nurse will have medication administration skills checked at least quarterly. Nurses that make omissions or need to enhance their competency skills will be required to participate in education in-services on medication administration policies and procedures.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345483	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 281	<p>Continued From page 3</p> <p>the July MAR for each day from 7/20/12 through the morning of 7/25/12 at 9:00 AM and 9:00 PM indicated the Nepro had not been given.</p> <p>During an interview on 8/2/12 at 2:50 PM the Assistant Director of Nursing (ADON) stated it was her expectation that nursing staff should call the physician for clarification of orders if they did not have the medication and should not make the decision to substitute medications on their own. The ADON explained nursing staff should not have written the note on the MAR that the facility did not provide Nepro because it was kept in the supply room or ordered if there was none available. She further explained nursing staff was responsible for reviewing the monthly physician orders and MAR's and should have noted that Nepro was not on the monthly physician's orders or MAR from 8/1/12 through 8/31/12 and should have added it and given it as ordered. She stated she expected nursing staff to check with other staff or a supervisor to get supplements for residents when they could not find them.</p> <p>During a telephone call to the pharmacy on 8/2/12 at 3:04 PM a technician explained Nepro should have been carried over from the July physician's orders to the August physician's orders unless it had been discontinued.</p> <p>During an interview on 8/2/12 at 3:44 PM with Resident #196's physician he explained he did not think the substitution of Rena-Vite with a generic multivitamin was harmful to the resident but nursing staff should have called him for clarification and they should not have substituted medications without calling him first. He further explained he expected for nursing staff to</p>	F 281	<p>participate in education in-services on the policy.</p> <p>4. The results of the audits will be presented to the Performance Improvement (PI) Committee meeting that is scheduled the third Wednesday of every month until compliance is 100% and for two months after that time. The members of the PI Committee include the Executive Director, Medical Director, DON, MDS Coordinator, Rehabilitation Manager, Dietary Manager, Social Services Director and Business Office Manager.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 281	<p>Continued From page 4</p> <p>administer medications and supplements as ordered.</p> <p>During an interview on 8/3/12 at 9:32 AM the Pharmacist verified Rena-Vite was the generic substitution of Nephro-Vite and was kept in the stock supply on the medication cart or in the medication room. He explained it was the facility's responsibility to request the medication from the pharmacy when they ran out or did not have the medication in stock when the resident was admitted.</p> <p>During a follow up interview on 8/3/12 at 10:31 AM the Pharmacist stated he verified with the pharmacy that dispensed medications to the facility they had not sent any Rena-Vite to the facility in the last six (6) months until they sent a bottle last night on 8/2/12. He explained the pharmacy would not have automatically sent it because it was up to nursing staff to let the pharmacy know when they didn't have it.</p> <p>During a follow-up interview on 8/3/12 at 10:46 AM the ADON stated Nepro was ordered from the central supply department inside the facility. She explained when nursing staff got an order for Nepro they gave it to the central supply technician and she checked to see if the item was in stock and if it wasn't she ordered it.</p> <p>During an interview on 8/3/12 at 3:52 PM the Central Supply Manager stated the nursing staff verbally told her when they needed supplies and if she placed the order by 2:00 PM it was delivered the next day. She further stated she remembered nursing staff asked her about Nepro recently and verified the invoice indicated she</p>	F 281			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 281	<p>Continued From page 5</p> <p>ordered the Nepro on 7/23/12 and it was delivered to the facility on 7/24/12 and was available for use.</p> <p>2. Resident #105 was admitted to the facility 6/7/12 with diagnoses that included gastrointestinal bleed. Review of physician orders revealed separate orders dated 7/25/12 and 7/30/12 to check stools for occult blood.</p> <p>On 8/3/12 at 10:35 AM the Assistant Director of Nursing (ADON) stated when an order is received to check stools for occult blood the nurses should write the order on the Medication Administration Record (MAR) and 24 hour report to alert nursing staff of the need. The ADON stated the test to check for occult blood is done by nursing staff in the facility. The ADON stated if the in house test is positive the sample is kept and 1) the physician is notified, 2) an order to have the stool checked by the lab is written and 3) the sample is sent out to the lab for testing.</p> <p>Review of the July 2012 MAR for Resident #105 noted an entry titled "guaic stools" (occult blood) on 7/25/12. Daily entries beside the notation included: 7/26/12-blank 7/27/12-an initial 7/28/12-a "0" 7/29/12-a "0" 7/30/12-a "0" 7/31/12- "in fridg"</p> <p>Review of bowel movement records for Resident #105 revealed stools on a daily basis from</p>	F 281			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 281	<p>Continued From page 6 7/25/12-until hospitalized on 8/1/12.</p> <p>In a follow-up interview on 8/3/12 at 11:15 AM the ADON stated the stool sample was not located in the refrigerator (as indicated on the resident's MAR) designated for specimens. The ADON also noted the lab was called and they had not received a stool sample or received a requisition for a test for occult blood. The ADON identified the licensed nurse (LN #7) that initiated on 7/27/12 and 7/31/12 indicating that the sample was in the "fridg". The ADON stated she reviewed the resident's bowel records and noted the resident had stools but could not explain why a sample had not been tested. The ADON stated nurses are expected to coordinate with the nursing assistants to perform the test for occult blood. The ADON also stated the 24 hour report from 7/25/12-8/1/12 was reviewed and the need to check Resident #105's stool for occult blood was not mentioned. The ADON stated the process for testing stool for occult blood was part of each nurses orientation.</p> <p>On 8/3/12 at 2:00 PM LN #7 stated that a stool sample from Resident #105 had been obtained and placed in the lab refrigerator. LN #7 stated she informed oncoming staff that the stool sample had been labeled and placed in the specimen refrigerator. LN #7 stated she was unaware that occult blood stool samples were done in house and didn't recall this had been part of orientation. LN#7 stated she assumed the oncoming nurses would have written a lab requisition slip for the occult blood test and didn't realize that couldn't be done until first tested in house and without a physician's orders.</p>	F 281			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345483	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 281	Continued From page 7 On 8/3/12 at 2:58 PM the physician of Resident #105 stated although tests should be done as ordered he didn't suspect the resident had gastrointestinal bleeding based on other lab results.	F 281			
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to provide Physician ordered restorative services consistently for one (1) of one (1) residents. (Resident #12) The findings are: Resident #12 was admitted to the facility with diagnoses including Osteoporosis, Epilepsy, and left Hemiparesis with spasticity. A quarterly Minimum Data Set (MDS) dated 05/24/12 revealed Resident #12 was cognitively intact and received restorative nursing programs for two (2) days during the seven (7) day review period. A care plan dated 12/14/11 and last reviewed on 05/28/12 stated Resident #12 was recently discharged from therapy and was at risk for decline in physical functioning. The goal was to maintain current level of physical functioning. Care plan interventions to address this included: to provide five (5) times a week for twelve (12) weeks: active and passive range of motion	F 311	<u>Corrective Action for the Resident Found with Deficient Practice:</u> 1. Resident #12 has received restorative services per physician's order since 08/04/12; <u>Corrective Action for Having Potential for Same Deficient Practice:</u> 1. All residents have been identified as having potential to be affected by this practice. 2. Beginning 08/28/12, each restorative aide will report at end of shift to ADON/SDC, or Designee any resident who has not received restorative services and the reason why.. 3. SDC will inservice all restorative aides by 08/31/12 on the importance of providing ADL services to residents.. <u>Measures Put Into Place or Systemic Changes to Ensure Deficient Practice Does Not Reoccur:</u> 1. Beginning 08/31/12, weekly for 30 days, then monthly for 3 months, the ADON/SDC and/or Designee will audit resident restorative records for 100% compliance.	8/31/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 311	<p>Continued From page 8</p> <p>(ROM) to bilateral hips, transfer exercises, ambulation with a rolling walker, and active ROM to bilateral lower extremities. The care plan also specified staff would observe for changes in physical functioning and refer to therapy as indicated.</p> <p>A rehabilitation services multidisciplinary screening tool dated 04/23/12 recommended ambulation and ROM services with restorative.</p> <p>Review of Physician's orders for August 2012 revealed an entry dated 03/13/12 for the following to be provided five (5) times a week for twelve (12) weeks: active ROM to left ankle, passive ROM to left lower extremity, active ROM to lower extremities, and ambulate with rolling walker.</p> <p>Review of Resident #12's restorative flow sheets for 07/01/12 through 07/28/12 revealed the following:</p> <ul style="list-style-type: none"> - The week of 07/01/12 Resident #12 received restorative services one (1) day and the restorative aide (RA) documented restorative services were not provided the remaining days. - The week of 07/08/12 Resident #12 received restorative services three (3) days and RA documented restorative services were not provided the remaining days. - The week of 07/15/12 Resident #12 received five (5) days of restorative services. - The week of 07/22/12 Resident #12 received three (3) days of restorative services and the RA documented the resident's restorative services were held two (2) days due to a fall and an appointment. <p>During an Interview on 08/01/12 at 10:30 AM</p>	F 311	<p><u>2. Monitoring:</u></p> <ol style="list-style-type: none"> 1. A study will be initiated 08/31/12. The results will be reported monthly to the QA Committee and the Medical Director. The QA Committee meets the third Wednesday of each month when the above issues and results will be discussed by the committee and the Medical Director. Results will be aggregated, analyzed, trended, and revisions made available for review. Study designed to do the following: to assure restorative services are being provided to the residents. 2. The results will be reported to the QA Committee and the Medical Director. The QA Committee meets on the third Wednesday monthly when the above issues will be discussed by the committee and the Medical Director referring to providing restorative services to residents. Concurrent critiques and post critiques will be performed and recommendations and changed will be implemented as indicated by members of the interdisciplinary/QA team members. 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 311	<p>Continued From page 9</p> <p>Resident #12 stated she was not walked on 07/31/12 due to staffing and would not receive restorative services today (08/01/12) because the restorative nurse was assigned to monthly weights instead. Resident #12 further stated restorative services had been provided less consistently during July of 2012 and it was important to her to be ambulated at least five (5) days a week.</p> <p>An interview was conducted with RA #1 on 08/02/12 at 11:34 AM. During the interview the RA #1 stated she filled in for the RA #2, who usually provided restorative services, anytime RA #2 was off or on vacation. RA #1 confirmed she was providing restorative services the week of 07/29/12 because RA #2 was on vacation. RA #1 further stated she does not provide restorative services the days she is assigned monthly weights. RA #1 explained if she did not provide restorative services to a resident on any given day she would document this on the resident's flow sheet in the restorative notebook.</p> <p>During a follow-up interview on 08/03/12 at 09:58 AM RA #1 reviewed Resident #12's current restorative flow sheet and confirmed she had provided restorative services to Resident #12 on 07/30/12 and 08/03/12. The interview further revealed Resident #12 did not receive restorative services on 07/31/12, 08/01/12, or 08/02/12 because RA #1 was off and/or assigned monthly weights on those days.</p> <p>An interview with licensed nurse (LN) #1 on 08/03/12 at 2:57 PM revealed she reviewed the resident flow sheets in the restorative note book weekly and made referrals to therapy as needed.</p>	F 311		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345483	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 311	Continued From page 10 LN #1 stated she was aware residents did not always receive restorative services five (5) times a week as ordered and had asked the RAs to document why services were not provided when they documented on the flow sheet. LN #1 further stated the RAs were frequently pulled to work the floor and they were doing the best they could to provide restorative services as ordered. The interview further revealed LN #1 had just referred Resident #12 to therapy due to decreased strength and endurance. An interview was conducted with the Administrator and the Assistant Director of Nursing (ADON) on 08/03/12 at 4:48 PM. During the interview the Administrator and the ADON stated they were not aware Resident #12 had not been receiving restorative services consistently and expected residents' to receive restorative services as ordered. The ADON recalled Resident #12 was ill the first week of July 2012 and probably did not feel up to restorative services. The ADON indicated she had tried to remove the monthly weights from the RAs responsibilities but had problems with inconsistent weights when the nursing assistants were assigned the task. The ADON further stated the last time she could recall RAs being pulled to the floor was in January of 2012.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 312	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff failed to provide lip moisturizer with mouth care and failed to provide nail care for two (2) of two (2) sampled residents observed for activities of daily living. (Resident # 122 and Resident #18).</p> <p>The findings are:</p> <p>1. Resident #122 was admitted to the facility with diagnoses including reflux in the esophagus, difficulty swallowing, and a stroke.</p> <p>The most recent quarterly Minimum Data Set (MDS) dated 6/28/12 indicated Resident #122 had impairment in short term and long term memory and severe impairment in cognition for daily decision making. The MDS also indicated Resident #122 required extensive assistance from staff for activities of daily living. The MDS titled "Section K" indicated no weight loss and feeding tube 501 cc's or greater per day.</p> <p>A review of a Physician's Order dated 5/29/12 indicated Biotene Moisturizing Mouth Spray (1) spray on mouth swab and swab mouth four times daily as needed for dry mouth.</p> <p>A review of monthly Medication Administration Records (MAR's) dated 6/1/12 through 8/3/12 indicated Resident #122 had not received Biotene Moisturizing Mouth Spray on any day during this time period.</p> <p>A review of a care plan with a revised date of</p>	F 312	<p><u>Corrective Action for the Resident Found with Deficient Practice:</u></p> <p>1. For Resident #122, mouth care was provided. Physician's orders were obtained for Biotene Moisturizing mouth spray, 2 sprays TID and PRN after mouthcare, and oral care each shift.</p> <p><u>Corrective Action for Having Potential for Same Deficient Practice:</u></p> <p>1. All residents have been identified as having potential to be affected by this practice.</p> <p>2. On 08/29/12, an audit of mouth care and nail care to residents was conducted and was found with 100% compliance.</p> <p><u>Measures Put Into Place or Systemic Changes to Ensure Deficient Practice Does Not Reoccur:</u></p> <p>3. During Morning Angel Rounds conducted 5x/wk by the Interdisciplinary Team, any observations of mouth care and nail care not being given to residents will be reported to the ADON and will be provided immediately.</p> <p>4. CNAs will check for nail care and oral care needs of all residents during routine showers and during rounds and will report any needs to the charge nurse per policy and procedure.</p> <p>5.</p> <p><u>Monitoring:</u></p> <p>1. A Study was initiated 08/29/12 and the Results aggregated, analyzed, trended, and revisions made available for review. Study designed to do the following: to ensure mouth care and nail care is being provided to residents.</p>	8/29/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 312	<p>Continued From page 12</p> <p>7/9/12 Indicated a problem statement that Resident #122 was at risk for alterallon in nutritional status related to a feeding tube and recelved nothing by mouth. The approaches indicated to assess hydration status and mucous membranes in Resident #122's mouth.</p> <p>During an observation on 8/1/12 at 9:05 AM Resident #122 was lying in bed. She was breathing with her mouth open and her tongue was coated with yellowish white debris. Resident #122 attempted to speak but her tongue stuck to the roof of her mouth.</p> <p>During an observation on 8/2/12 at 8:58 AM Resident #122 was lying in bed and her lips were very dry with dark brown caked debris on the upper and lower lips. Resident #122 attempted to speak but had difficulty because her tongue stuck to the roof of her mouth. .</p> <p>During an observation on 8/2/12 at 10:06 AM Resident #122 was sitting up in a chair next to her bed. There was a dark black scab on her right (R) lower lip and an ulcer on her (R) upper lip.</p> <p>During an observation on 8/2/12 at 10:08 AM the wound care nurse changed a dressing around Resident #122's feeding tube. Resident #122 was breathing with her mouth open and there was thick yellowish debris with dark black patches on her tongue and her lips were dry and cracked.</p> <p>During an interview on 8/3/12 at 11:10 AM with a hospice nurse she stated hospice had a nursing assisiant who visited twice each week and did</p>	F 312	<p>2. The results will be reported monthly to QA Committee and the Medical Director. The QA Committee meets on the third Wednesday of the month. The above issues will be discussed by the committee and the Medical Director regarding mouth care and nail care being provided to residents. Concurrent critiques and post critiques will be performed and recommendations or changes will be implemented as indicated by members of the</p> <p>Interdisciplinary/QA team members.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV	STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 312	<p>Continued From page 13</p> <p>mouth care during every visit. She explained they have had some issues in last couple of months because Resident #122 had increased secretions in her mouth. She further explained when they did mouth care with swabs, it triggered more secretions. She stated she was not sure if they had specifically talked about oral care as part of Resident #122's personal care but it's been especially important during the last couple of weeks with her increased secretions. She explained Resident #122 normally had something in her bedside table to moisten her lips and they used a mouth moisturizer in the past that worked well.</p> <p>During an interview on 8/3/12 at 11:46 nursing assistant (NA) # 1 stated she used pink swabs and mouthwash to clean inside Resident #122's mouth. She explained when she did Resident #122's mouth care she had to go toward the back of her throat because there's thick phlegm always back there and it's coated on her tongue. She stated the nursing assistants had to rub Resident #122's tongue to try and get the phlegm off but it was difficult to get off. She explained she usually provided mouth care for Resident #122 once per day. NA #1 stated they did not use any kind of moisturizer on Resident #122's lips and she had mouth ulcers all the time.</p> <p>During an interview on 8/3/12 at 12:11 PM the Assistant Director of Nurses (ADON) stated it was her expectation mouth care should be done as needed to keep the resident's mouth clean. She explained Resident #122 had a physician's order for Biotene spray as a moisturizer to be used as needed and verified it had not been documented as given on the MAR's dated 6/1/12</p>	F 312		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 312	<p>Continued From page 14 through 8/3/12.</p> <p>2. A review of a facility document titled "Fingernail Care" and not dated indicated nail care included daily cleaning and regular trimming. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his/her skin.</p> <p>Resident #18 was admitted to the facility with diagnoses including arthritis, pain and a stroke.</p> <p>The most recent quarterly Minimum Data Set (MDS) dated 5/31/12 indicated Resident #18 had impairment in short term and long term memory and was moderately impaired in cognition for daily decision making.</p> <p>A review of a care plan dated 7/4/12 with a problem statement indicated Resident #18 was at risk for skin breakdown. On 7/4/12 resident's left ring finger was cut and a steri strip was applied. The approaches included doing full body assessments on bath/shower days noting any signs or symptoms of skin breakdown.</p> <p>A review of nurse's notes dated 7/4/12 indicated Resident #18's left (L) ring finger nicked while her nails were trimmed. The resident's finger was cleaned, a steri strip was applied and the nurse, physician and responsible party were all notified.</p> <p>A facility document titled "Weekly Nursing Summary" for Resident #18 and dated 8/1/12 indicated in a section for "nails" to cut as needed by staff.</p>	F 312			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 312	<p>Continued From page 15</p> <p>During an observallon on 8/1/12 at 11:44 AM Resident #18's finger nalls were long on both hands.</p> <p>During an interview on 8/1/12 at 11:45 AM Resident #18 stated she did not like for staff to cut her nalls because they cut her nalls too close and they cut her ring finger on her left (L) hand twice. She further stated she wanted for someone to file her nalls and she thought they needed to be filed now. She also stated they didn't clean under her nalls but she would like for them to be cleaned.</p> <p>During an observallon on 8/2/12 at 12:27 PM Resident #18 was sitting in her wheel chair in her room with her over bed table in front of her and was eating lunch from her meal tray. The finger nalls were long and uneven on both of her hands.</p> <p>During an observation on 8/3/12 at 11:05 AM Resident #18 was sitting in her room in her wheelchair with her right hand resting on her over bed table. The middle two (2) fingers of her right (R) hand were stained with a light brown substance at the ends of the nalls and her finger nalls on both hands were long and uneven.</p> <p>During an interview on 8/3/12 at 11:30 AM with Nursing Assistant (NA) #2 she explained staff assisted Resident #18 with her personal care and she was very cooperative during care. She stated she thought they trimmed and cleaned her nalls every couple of weeks but was not sure when her nalls were last cleaned.</p> <p>During an interview on 8/3/12 at 12:05 PM the Assistant Director of Nursing (ADON) stated it</p>	F 312			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV	STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 312	Continued From page 16 was her expectallon that residents should have their nails filed and cleaned routinely. She verified Resident #18's nails were long, needed to be filed and looked like the nails on her right (R) hand were stained and had white debris under them.	F 312		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews facility staff failed to check feeding tube placement by auscultation prior to medication administration in one (1) of one (1) residents observed with tube feedings. (Resident #122). The findings are: A review of a facility document titled "Feeding Tube-Instilling Medication" and not dated indicated to attach syringe to end of the tube and insert 20 cubic centimeters (cc's) of air and check placement and patency by auscultation (the act of listening, either directly or through a stethoscope or other instrument, to sounds within the body).	F 322	<u>Corrective Action for the Resident Found with Deficient Practice:</u> Orders to "Check placement of PEG tube prior to feeding" were clarified and placed on Medication Administration Record (MAR) of resident #122 on 08/27/12. <u>Corrective Action for Having Potential for Same Deficient Practice:</u> All residents have been identified as having potential to be affected by this practice. Audits to clarify orders to check tube placement of any resident receiving tube feedings were done and were verified to be in 100% compliance. <u>Measures Put Into Place or Systemic Changes to Ensure Deficient Practice Does Not Reoccur:</u> Facility nurses have received education on the facility's "Feeding Tube - Instilling Medication" which includes transcribing orders for checking placement every shift on the resident's MAR) and "Physician Order Transcription" policies on 08/29/12 through 08/31/12. Tube feeding policies and procedures will be provided to newly hired licensed nursing personnel during the 40-hour orientation period. All staff will be in-	8/31/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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)	(X6) COMPLETION DATE
F 322	<p>Continued From page 17</p> <p>Resident #122 was admitted to the facility with diagnoses including reflux in the esophagus, difficulty swallowing, and a stroke.</p> <p>The most recent quarterly Minimum Data Set (MDS) dated 6/28/12 indicated Resident #122 had impairment in short term and long term memory and severe impairment in cognition for daily decision making. The MDS also indicated Resident #122 required extensive assistance from staff for activities of daily living. The MDS titled "Section K" indicated no weight loss and feeding tube 501 cc's or greater per day.</p> <p>A review of a care plan with a revised date of 7/9/12 indicated a problem statement that Resident #122 was at risk for alteration in her nutritional status due to a feeding tube and received nothing by mouth. The approaches indicated to send Resident #122 to hospital for feeding tube replacement, administer tube feedings as ordered, assess for signs and symptoms of anxiety, and provide distraction and positioning to decrease resident's focus on the tube.</p> <p>A review of monthly physician's orders dated 8/1/12 through 8/31/12 indicated Resident #122 received Tylenol 500 milligrams (mg) twice daily into the feeding tube.</p> <p>A review of a facility document titled "Daily Care Guide" and dated 8/3/12 indicated under interventions to always place blanket or cover over resident's feeding tube so she will have something to "pull on."</p> <p>During an observation on 8/2/12 at 12:33 PM</p>	F 322	<p>serviced on feeding tube P&P's administration at least annually. Newly hired licensed staff will have documented competencies within 30 days of hire.</p> <p><u>Monitoring :</u></p> <p>The facility's ADON and SDC provide "Tube Feeding" audits of MARs to verify orders and "Check placement every shift" is documented, as well as tube feeding administration and skills proficiency reviews for facility nurses on a monthly basis. Nurses that make omissions or need to enhance their competency skills will be required to participate in education in-services on medication administration policies and procedures.</p> <p>SDC will utilize audit tool and audit 10 – 15% of nurses each month on the proficiency of the nurses providing tube feedings (including checking placement),. Nurses that make omissions will be required to participate in education in-services on the policy. The audit will be completed for 6 months. The SDC will ensure nurses are observed, compile error rates and bring data to monthly Performance Improvement (PI) meetings for review, need for further recommendations, consideration of addition training, or modification of the above process monthly for the next 6 months for further tracking and follow-up until compliance is 100%.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 322	<p>Continued From page 18</p> <p>during medication administration Licensed Nurse (LN) #6 washed her hands and put on gloves. She disconnected Resident #122's feeding tube from tubing connected to a feeding pump and inserted a syringe into the feeding tube. She pulled back slightly on the plunger of the syringe and removed the syringe from the feeding tube. LN #6 mixed Tylenol 500 mg. in the syringe with water and inserted it into the feeding tube. She removed the syringe again and poured clear water into the syringe and inserted it into the tube and flushed it. She removed the syringe and reconnected the tubing from the feeding pump, turned the pump on, removed her gloves and washed her hands.</p> <p>During an interview on 8/2/12 at 12:39 PM with LN #6 she stated she was not sure of the facility policy to check placement of the feeding tube because she had only been in the facility a couple of weeks. She stated she thought tube placement should be checked every shift and documented on the Medication Administration Record (MAR). LN #6 verified there was no documentation on Resident #122's MAR to check placement of the feeding tube and she did not listen with a stethoscope to check for tube placement before she gave Resident #122 her medication. She further stated Resident #122 had a history of pulling out her feeding tube and staff had to keep it covered so she wouldn't pull on it.</p> <p>During a follow up interview on 8/2/12 at 2:12 PM with LN #6 she stated she found out the facility policy was to check for tube placement by auscultation and she should have used a stethoscope to listen and check for tube</p>	F 322			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV	STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 322	Continued From page 19 placement before she gave Resident #122's medication.	F 322		
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to ensure an oxygen cylinder was securely stored for one (1) of two (2) sampled residents. (Resident #196)</p> <p>The findings are:</p> <p>Resident #196 was admitted with orders for oxygen at 2 liters a minute to keep oxygen levels</p>	F 328	<p><u>Corrective Action for the Resident Found with Deficient Practice:</u></p> <p>The oxygen canister that was not securely stored in a carrier per LCCA policy was removed from the room of resident #196 and placed in proper storage on 08/02/12.</p> <p><u>Corrective Action for Having Potential for Same Deficient Practice:</u> All residents have been identified as having potential to be affected by this practice. An audit was done on 08/02/12 to check the entire facility for any oxygen canisters that may not be properly stored was done and was verified to be in 100% compliance.</p>	9/7/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 328	Continued From page 20 at 90% or greater. On 8/2/12 at 11:41 AM Resident #196 was observed in her room, in bed. Resident # 196 was wearing a nasal cannula and had oxygen at 2 liters a minute infusing via an oxygen concentrator. Three oxygen cylinders were observed in the room; one on the back of the resident's wheelchair, one in a wheeled oxygen carrier by the entrance of the room and one freestanding, against the wall by the entrance of the room. At approximately 11:50 AM a transportation aide entered the room to assist the resident to a medical appointment. Resident #196 transferred herself from bed into the wheelchair while the transportation aide transferred the resident's oxygen source from the concentrator to the portable tank on the back of the wheelchair. At approximately 12:00 PM the resident was assisted from her room, to the facility van by the transportation aide. An observation at 12:30 PM revealed the freestanding oxygen tank remained unsecured in the room of Resident #196. Resident #196 remained out of the facility until approximately 4:30 PM. On 8/2/12 at 5:00 PM the Assistant Director of Nursing (ADON) stated all oxygen cylinders (whether full or empty) should be stored secure in a stand or wheeled oxygen carrier. The ADON stated the wheeled oxygen carriers were to be used by staff to transport oxygen cylinders from the storage room to resident rooms. At the time of the interview the ADON observed the freestanding, unsecured oxygen cylinder stored against the wall, in the room of Resident #196. A rolling walker was approximately twelve inches	F 328	<u>Measures Put Into Place or Systemic Changes to Ensure Deficient Practice Does Not Reoccur:</u> All facility associates, licensed as well as unlicensed associates have received education on the facility's "Oxygen Therapy" on 08/03/12 through 09/07/12. Oxygen therapy policies and procedures will be provided to newly hired licensed nursing personnel during the 80-hour orientation period. All staff will be in-serviced on oxygen canister storage P&P's administration at least annually. Newly hired licensed staff will have documented competencies regarding oxygen canister storage within 30 days of hire. <u>Monitoring</u> The facility's associates that perform "Angel" or compliance rounds shall verify all oxygen canisters are properly stored in any area they observing and at any other time while they are in the facility and record any issues on the audit sheet. ADON and SDC shall review audits with the entire clinical team at the morning clinical meeting. Associates that fail to properly secure oxygen canisters per P&P will be required to participate in education in-services on oxygen therapy policies and procedures. The audit will be brought to the monthly Performance Improvement (PI) meetings for review, need for further recommendations, consideration of addition training, or modification of the above process monthly for the next 6 months for further tracking and follow-up until compliance is 100%.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 328	Continued From page 21 from the unsecured oxygen cylinder. The ADON stated the oxygen cylinder should not have been left unsecured and freestanding. The ADON looked at the pressure gauge on the oxygen cylinder and noted to it was in the "red", indicating it was empty. The ADON removed the oxygen cylinder from the room and stated she would try to determine who left it unsecured. The ADON also stated she would check on the facility policy regarding storage of oxygen cylinders. On 8/3/12 at 12:00 PM the ADON stated she spoke with all staff that worked with Resident #196 on 8/2/12 and was unable to determine who left the cylinder unsecured in her room. The ADON verified the facility policy included, "oxygen cylinders may not be left freestanding, they must be securely fastened at all times."	F 328			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	<u>Corrective Action for the Resident Found with Deficient Practice:</u> The family and physician was notified and the orders for Amiodarone was clarified, corrected on Medication Administration Record (MAR) and the correct medications were placed in the medication cart for Resident #44 on 08/02/12. Physician's clarification order was to decrease Amiodarone to 200 mg daily. <u>Corrective Action for Having Potential for Same Deficient Practice:</u> All residents have been identified as having potential to be affected by this practice. A representative from the pharmacy met with the survey team and facility clinical administrative staff to discuss a plan of action so an incorrect dose calculation does not happen again. A review by the pharmacy representative of all medication orders was done on 08/03/12 and no other incorrect dose calculations were revealed.	8/21/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345483	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 329	<p>Continued From page 22</p> <p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Pharmacist interviews the facility failed to ensure a resident's drug regimen was free from an excessive dose of a medication for one (1) of ten (10) sampled residents. (Resident #44)</p> <p>The findings are:</p> <p>Resident #44 was admitted to the facility with diagnoses including Atrial Fibrillation. Review of medical record revealed a Physician's order dated 06/21/12 to reduce Resident #44's Amlodarone (antlarrhythmic) to 150mg (milligrams) daily. Further review of the medical record revealed Resident #44's previous order was for Amiodarone 200mg by mouth daily.</p> <p>Observations of Resident #44's medication supply in the 400 hall medication cart on 08/02/12 at 2:40 PM revealed two (2) unit dose medication cards labeled "Amlodarone HCL 200mg tablet take 1 and 1/4 tab (150mg) by mouth everyday". Further observation revealed one (1) of the unit dose medication cards contained a Intact 200mg tablet of Amlodarone HCL and the second unit dose medication card contained 1/4 of a 200mg Amiodarone HCL tablet. There were no additional unit dose cards containing Amiodarone</p>	F 329	<p><u>Measures Put Into Place or Systemic Changes to Ensure Deficient Practice Does Not Reoccur:</u></p> <p>Beginning 08/03/12, for six weeks, two pharmacists will check medication orders at the pharmacy site. Results will be presented weekly to the pharmacy QA committee. Depending on results, the pharmacy will make recommendations and/or changes to their process.</p> <p>Facility nurses have received education on the facility's "Physician Orders" policy and procedure. Physician orders require the signature or initial of two (2) nurses on the Physician Order, MAR and/or lab book. The nurse taking off the order is to record the order on the MAR and/or lab book and initial, and the night shift nurse will review physician orders for the day on all charts responsible for, verify the order was taken off and documented, make any corrections as needed, then initial the MAR and/or lab book. Any miscalculations, discrepancies or confusing orders will be immediately reported to a supervisor before administration of the medication. For any physician orders that may be confusing, illegible or contrary to standards of practice, facility nurses received one to one in-service education on the facility's medication administration policies and "Physician Order Transcription" and "Physician Orders Clarification" policies on 08/02/12 through 08/17/12. Medication administration policies and procedures will be provided to newly hired licensed nursing personnel during the 40-hour orientation period. All</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 329	<p>Continued From page 23 for Resident #44 on the medication cart.</p> <p>Review of Resident #44's June of 2012 Medication Administration Records (MAR) revealed Amlodarone 150mg (hand written entry) was initialed as administered by a licensed nurse 06/21/12 through 06/30/12. Review of Resident #44's July and August of 2012 MARs revealed the entry for Amlodarone HCL 200mg tablet take 1 and 1/4 tab (150mg) by mouth everyday was initialed as administered by a licensed nurse. As a result, Resident #44 received Amlodarone 250mg by mouth daily instead of the intended reduced dose of Amlodarone 150mg for 43 days.</p> <p>An Interview was conducted with the Director of Nursing (DON) on 08/02/12 at 2:45 PM. The DON reviewed Resident #44's August 2012 Physician's orders and stated the Amiodarone order was not clear. The DON further stated if a medication order was not clear he expected nursing staff to clarify the order before administering the medication. The interview further revealed two nurses reviewed residents' Physician's orders and Medication Administration Records for accuracy monthly to prevent medication errors.</p> <p>During a telephone interview on 08/02/12 at 2:50 PM the Pharmacist verified Resident #44 had an order in the computer system dated 06/21/12 to take one (1) and 1/4 tablets of Amlodarone 200mg by mouth daily to equal Amiodarone 150mg by mouth daily. The Pharmacist confirmed Resident #44 would have received Amlodarone 250mg by mouth daily due to the incorrect dose calculation of the Physician's order entered on the MAR by the Pharmacy.</p>	F 329	<p><i>staff will be in-serviced on medication administration at least annually. Newly hired licensed staff will have documented competencies within 30 days of hire.</i></p> <p>Monitoring:</p> <p>The contracting pharmacy (OmniCare) will provide "MedPass" audits (medication administration and skills proficiency reviews for facility nurses on a monthly basis. Every facility nurse will have medication administration skills checked at least quarterly. Nurses that make omissions or need to enhance their competency skills will be required to participate in education in-services on medication administration policies and procedures.</p> <p>In order to monitor the accuracy of physician orders received from OmniCare, the ADON and SDC will verify all physician orders are properly documented and followed using a "Physician Order Audit". They will review all orders</p> <p>pharmacy calculations and document any discrepancies on the audit form and report any discrepancies in morning clinical meeting where appropriate action can be immediately taken to correct any issue. .</p> <p>This audit began 08/03/12 and will be performed daily until 08/06/12 weekly until 11/07/12 and then as needed. Nurses that make omissions will be required to participate in education in-services on the policy.</p> <p>The clinical team shall review all new admission orders on the next clinical meeting following admission.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 329	Continued From page 24 A telephone interview with the Pharmacy Manager on 08/02/12 at 3:30 PM revealed the pharmacy received a Physician's order dated 06/20/12 to reduce Resident #44's Amlodarone to 150mg by mouth daily. The Pharmacy Manager explained the order had been keyed into the system incorrectly by the pharmacy technician and the Pharmacist did not pick up on the incorrect dose calculation during the final review. The Pharmacy Manager stated the Pharmacy "misdispensed" the medication and confirmed a total dose of Amlodarone 250mg daily had been sent to the facility since 06/21/12. During an interview on 08/02/12 at 3:25 PM Resident #44's Physician stated he had just examined the resident and did not expect any adverse effects. The Physician explained he had decreased Resident #44's Amidarone on 06/20/12 because the "elderly don't handle it very well". The Physician further stated Resident #44's pulse had remained stable during the time she received the increased dose of Amlodarone and had ordered a TSH (thyroid stimulating hormone) to be drawn on 08/03/12. An interview with licensed nurse (LN) #2 on 08/02/12 at 3:15 PM revealed she reviewed Residents #44's new August 2012 MAR against the July 2012 MAR and any new orders written in July of 2012. LN #1 stated she did not notice the incorrect dose calculation for Amlodarone when she signed off on the August 2012 MAR because it was identical to the order on the July 2012 MAR. A telephone interview with LN #3 on 08/03/12 at	F 329	The DON will collect data on any issues with physician orders, compile error rates and bring data to monthly Performance Improvement (PI) meetings for review, and need for further recommendations, consideration of addition training, or modification of the above process monthly for the next 3 months for further tracking and follow-up. The results of the audits will be presented to the Performance Improvement (PI) Committee Meeting that is scheduled the third Wednesday of every month until compliance is 100% and for two months after that time.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 329	Continued From page 25 6:15 PM revealed she reviewed Resident #44's July 2012 MAR against the June 2012 and any new orders written in June of 2012. LN #2 stated she did not notice the incorrect dose calculation for Amiodarone when she signed off on the July 2012 MAR. A follow up interview was conducted with the Pharmacist on 08/03/12 at 9:20 AM. The Pharmacist stated his usual practice was to review all new orders written since his previous visit and review the current Physician's order sheet for accuracy. Further interview revealed the Pharmacist had completed monthly pharmacy reviews for Resident #44 on 06/22/12 and 07/17/12 and noted her Amlodarone had been decreased in his note on 06/22/12. The Pharmacist stated he had missed the dosage discrepancy when he completed his reviews in July and August of 2012. In addition, the Pharmacist indicated he had reviewed Resident #44's pulse rates in her medical record and did not see any negative outcomes due to the administration of the incorrect dose of Amlodarone.	F 329			
F 431 SS=D	483.80(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431	<u>Corrective Action for the Residnet Found w/th Deficient Practice:</u> The expired insulin vial for resident #50 was removed from medication cart immediately after notification during the survey. <u>Corrective Action for Having Potential for Same Deficient Practice:</u> Residents receiving medications have the potential to be affected by this allegedly deficient practice.	8/31/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 431	<p>Continued From page 26</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to remove expired medication from one (1) of five (5) medication carts.</p> <p>The findings are:</p> <p>Observation of the 500/600 hall medication cart on 8/3/12 at 12:04 p.m. revealed a vial of fast-acting insulin for Resident #50 with an opened date of 6/20/12 written on a tag on the bottle.</p>	F 431	<p>The ADON and SDC will have conducted an audit of all medication carts by 08/30/12 to ensure the medication carts are 100% compliant and no expired medications are present.</p> <p><u>Measures Put Into Place or Systemic Changes to Ensure Deficient Practice Does Not Reoccur:</u></p> <p>Facility nurses have received education on the facility's "Insulin Administration, Documentation and Storage" policy. An "opened date" and a 28 - day "expiration date" shall be written on the insulin vial when opened. All expired medications shall be removed from the medication cart prior to expiration of the medication. Different types of insulin vials shall be kept separated in the medication cart. Failure to follow this policy will result in re-education and progressive discipline.</p> <p>Facility nurses received in-service education on the facility's insulin administration policies on 08/03/12 through 08/31/12. Medication administration policies and procedures will be provided to newly hired licensed nursing personnel during the 40-hour orientation period. All staff will be in-serviced on medication administration at least annually. Newly</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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)	(X6) COMPLETION DATE	
F 431	Continued From page 27 Review of the August 2012 Medication Administration Record revealed a current order for the Insulin for Resident #50. An interview was conducted with Licensed Nurse (LN) #4 on 8/3/12 at 12:10 p.m. The nurse confirmed the date written on the tag on the vial was 6/20/12 and stated the Insulin was still in use for Resident #50. When asked when the Insulin was considered expired, the nurse stated he did not know. Interview with the Unit Manager (UM) on 8/3/12 at 12:17 p.m. revealed the vial of Insulin expired 28 days after opening. The UM also said a reference list that included information about insulin expiration dates was posted in the Medication Administration Record (MAR) and she pointed it out to LN #4. During an interview on 8/3/12 at 1:26 p.m., the Assistant Director of Nursing (ADON) said nurses were responsible for checking expiration dates before giving medications and the expired Insulin should not have been given. The ADON said nurses were expected to check the reference list in the MAR for expiration information for medications. The ADON also stated if nurses did not know when medications expired or could not find expiration information, she expected them to ask her, the UM on duty, or call the pharmacy.	F 431	hired licensed staff will have documented competencies within 30 days of hire. <u>Monitoring:</u> The facility's ADON and SDC and the contracting pharmacy (OmniCare) will provide "MedPass" audits (medication administration and skills proficiency reviews for facility nurses as well as medication cart audits on a monthly basis. Nurses that make omissions will be required to participate in education in-services on medication administration policies and procedures. The ADON or designee will audit medication carts 1 times per week for the next 90 days, compile error rates and bring data to monthly Performance Improvement (PI) meetings for review, and need for further recommendations, consideration of addition training, or modification of the above process monthly for the next 3 months for further tracking and follow-up, until compliance is 100% and for two months after that time.		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 465	<p>Continued From page 28 residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure that two (2) of three (3) automatic ice dispensers were clean.</p> <p>The findings are:</p> <p>An observation on 8/1/12 at 2:35 pm revealed an automatic ice dispenser with a removable drainage tray in the main dining room. A large amount of a black gelatinous substance was observed around the edges of the removable tray and in the base of the tray around the drain.</p> <p>An observation with the Dietary Manager on 8/2/12 at 11:50 am revealed the automated ice dispenser in the dining room continued to have a large amount of a black gelatinous substance around the edges and in the base of the removable drainage tray. A black gelatinous substance was also observed on the interior portion of the ice shoot. The Dietary Manager ran a gloved hand over the black gelatinous substance surrounding the rim of the removable tray and the substance was easily transferred to her gloved hand. The Dietary Manager revealed it was "probably mold", and that housekeeping was responsible for cleaning the ice dispenser.</p> <p>An observation on 8/2/12 at 12:15 pm revealed an automated ice dispenser with a removable drainage tray in the six hundred hall nourishment room. A large amount of a hairy, brown substance covered two-thirds of the base of the</p>	F 465	<p><u>Corrective Action for the Resident Found with Deficient Practice:</u></p> <ol style="list-style-type: none"> The removable drainage tray has been replaced on the ice machine and the ice machine cleaned in the main dining room. The removable drainage tray has been replaced on the ice machine and the ice machine cleaned on the 600 hall and a grate has been ordered to be placed on the machine. This grate shipped 08/27/12 and is expected to arrive at the facility within 3-4 days and will immediately be placed on the ice machine. <p><u>Corrective Action for Having Potential for Same Deficient Practice:</u></p> <ol style="list-style-type: none"> All residents have been identified as having potential to be affected by this practice. Ice machine located on 200 hall was audited on 08/02/12 and was found to be 100% compliant with cleanliness. Maintenance Director will monitor future compliance to ensure alleged deficient practices do not reoccur by conducting weekly audits and recording findings on a log that will be presented to the QA committee each month for three months. <p><u>Measures Put Into Place or Systemic Changes to Ensure Deficient Practice Does Not Reoccur:</u></p> <ol style="list-style-type: none"> Maintenance Director and Assistant Maintenance Director will conduct weekly audits and record findings on a log to ensure all ice machines including the trays are clean.]Audits will be 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 465	<p>Continued From page 29</p> <p>drainage tray and encompassed the interior of the drainage tube. A hairy, brown substance was also observed under the rim of the removable tray and on the inside of the ice shoot. The assistant director of nursing (ADON) also observed the ice dispenser and the brown, hairy substance around the drainage tube was easily transferred onto her gloved finger. The ADON revealed she did not know what the substance was and confirmed that maintenance was responsible for cleaning the ice dispensers. The ADON did not know the last time the ice dispenser had been cleaned and it was her expectation that it was clean.</p> <p>An interview with Housekeeper #1 on 8/2/12 at 12:20 pm revealed all three (3) ice dispensers were supposed to be wiped down twice a week and the tray should be cleaned twice a week.</p> <p>An interview with Maintenance #1 on 8/2/12 at 12:25 pm revealed he was not sure when the ice dispenser was cleaned or who was responsible for cleaning the ice dispenser.</p> <p>An interview with the Maintenance Director on 8/2/12 at 12:35 pm clarified maintenance was responsible for cleaning the automated ice dispensers in the facility. The interview further revealed the ice dispensers were cleaned every six (6) months by an outside provider. The interview revealed the outside of the ice dispensers were cleaned one (1) time a month.</p> <p>An interview with the Maintenance Director on 8/3/12 at 2:00 pm revealed ice dispensers were taken apart and maintenance was performed every three (3) months by an outside provider. The maintenance included cleaning, sanitizing</p>	F 465	<p>ongoing, as they are part of an internal computerized program that reveals system impairments.</p> <p><u>Monitoring:</u></p> <ol style="list-style-type: none"> 1. Study was initiated 08/03/12 and the Results aggregated, analyzed, trended, and revisions made available for review. Study designed to do the following: ensure the ice machines including trays are clean. 2. The results will be reported by the Maintenance Director monthly for three months to QA Committee and the Medical Director. The QA Committee meets on the third Wednesday of each month and the above issues will be discussed by the committee and the Medical Director regarding the cleanliness of ice machines including trays. Recommendations and changes will be implemented. 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HENDERSONV			STREET ADDRESS, CITY, STATE, ZIP CODE 400 THOMPSON STREET 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 465	Continued From page 30 and inspection of the ice dispensers. The interview further revealed maintenance performed a visual inspection of the ice dispensers monthly, and his expectation was if the dispenser was visibly dirty maintenance staff should clean the dispenser.	F 465			