STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# D1SD11.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record reviews concluded the facility failed to honor the resident's preferences of foods to be served on his meal tray for 1 of 3 residents reviewed for nutrition (Resident # 57). The Findings included: Resident #57 was admitted to the facility on 11/10/14 with diagnoses which included end stage renal disease, renal dialysis, depression, morbid obesity, diabetes, protein calorie malnutrition, and others. The most recent Minimum Data Set (MDS) admission assessment dated 11/17/14 revealed resident #57 was cognitively intact and able to make decisions of daily living. Review of the food and beverage preference list dated 11/11/14 revealed dislikes as follows:	F 242	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and executed because it is required by provisions of Federal and State regulations. A. Resident #57 is no longer at the facility. The Dietary Manager completed an audit and made corrections for all residents' food preferences and tray cards on 2/9/15. B. The Dietary Manager and/or her designee will ensure all new residents will have an assessment of their food preferences and that they will be noted correctly on their tray cards at the time of admission. All resident food preferences will be reviewed and updated quarterly. The Dietary Manager educated all Dietary	3/5/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/01/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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 242	Continued From page 1 1. Milk 2. Cottage cheese 3. Cheese 4. Roast beef, meat loaf, and hamburger 5. Hotdogs 6. Pork chops, pork roast 7. Ham 8. Veal 9. Liver 10. Bacon, sausage 11. Tomatoes 12. Beans, lentils 13. White potatoes 14. Greens 15. Melons 16. Bananas 17. Orange juice 18. Tomato juice Review of Resident #57's tray cards for breakfast, lunch, and dinner dated 02/05/15 at 10 am revealed dislikes as follows: 1. Bacon, Sausage 2. Banana 3. Melon 4. Milk 5. Orange juice 6. Baked and dry beans, green peas 7. Ham, Pork 8. Tomato 9. White potatoes A review of the grievance concern dated 01/08/15 revealed Resident #57 expressed that he is not getting his food preferences including hard boiled eggs, and the kitchen had sent ham that he does not eat because of religious beliefs. Note on the grievance dated 01/14/15 and signed by the	F 242	personnel by 2/25/15 on the importance of accurately following resident food preferences. The Staff Development Coordinator will provide education through the orientation process for all newly hired Dietary personnel. C. The Dietary Manager and/or her designee will conduct audits of resident food preferences and tray card accuracy weekly for four weeks and monthly thereafter for four months to ensure compliance. D. The Quality Assurance Performance Improvement Committee will review for compliance monthly times four months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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 242	Continued From page 2	F 242		

Administrator revealed the grievance was reviewed, investigated and resolved.

During an observation on 02/04/15 at 12:40 PM Resident #57's lunch tray revealed he was provided ground meat, pasta, and a chopped green vegetable. The Resident stated he would not eat this because it did not look appetizing. Resident #57 further stated he particularly hates greens and just the sight of them turns his stomach.

An interview was conducted with Resident # 57 on 02/03/15 at 10:24 AM. He stated the facility kitchen continues to send me all kinds of food I am not supposed to have and that I do not like. They provide a packed lunch when I go to dialysis that sometimes includes bananas and my meal trays are served with ham, greens, mixed vegetables that contain peas which are on the list of dislikes. Resident #57 further stated he has discussed this issue with the facility and the kitchen manager many times without success. Resident #57 explained " I cannot have peas because they have phosphorus, and when they send these things on my plate especially greens it turns my stomach and I don ' t want to eat anything on that plate so I then have to keep ordering grilled cheese sandwiches " .

An interview was conducted with Nursing Aide (NA) # 4 on 02/05/15 at 2:21 PM. NA # 4 explained that Resident #57 eats fine but often complains that he was sent greens and ham that he does not like and were on his dislike list. She further explained that she had seen these items on his tray and she takes them away and brings him something else like sandwiches. NA # 4 stated that Resident #57 had informed the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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 242	Continued From page 3 of his dislikes before. An interview was conducted on 02/05/15 at 2:39 PM with the Dietary Manager (DM). The DM revealed the dietary aides and dietary cooks are responsible for checking trays of food to compare them to each tray card before they leave the dining room to make sure each resident is getting the correct foods, food forms, utensils, and their preferences regarding likes and dislikes. The DM further revealed Residents were interviewed on admission to complete the preference list with likes and dislikes and then transcribed to their tray card which was what was used for preparing the food trays. The DM explained Resident #57's dislikes were related to his preferences and religious beliefs. The DM reviewed Resident #57's tray card and preference list dated 01/11/15. The DM verified that the tray cards noting dislikes did not match the preference list. The DM further stated that based on this and the fact that he was still receiving foods that are on his dislike list that the facility was not honoring his choices for food preferences. An interview was conducted on 02/05/15 at 4:41 PM with the Administrator. The Administrator stated he expected Residents dietary preferences should have matched what was on the dietary tray cards. The Administrator further stated Residents should have received the foods they like and dietary staff would ensure all residents' likes and dislikes would be honored and the correct foods would be on their trays.	F 242		
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		3/5/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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 280	Continued From page 4 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update and revise resident care plans on 2 of 4 residents (resident #66 and #112) as the status of the residents changed. Findings include: 1. A record review of quarterly MDS dated 01/04/15 revealed resident #66 was admitted to the facility on 01/05/13 with hypertension and dementia. Resident was cognitively impaired and was coded as rarely or never understood. Resident #66 required extensive assistance for bed mobility, transfers, dressing, eating, toileting and personal hygiene. Resident #66 was coded as no for unhealed pressure ulcer and coded as no for healed pressure ulcers. A record review of weekly pressure ulcer tracking	F 280	A. Comprehensive Care Plans for residents #66 and #112 have been reviewed and revised to reflect accurate skin conditions. B. The Wound Report of 2/23/15 has been reviewed by the Director of Nursing and compared to current Care Plans. Necessary revisions have been made so that Care Plans reflect current wounds. All changes in skin integrity will be investigated by the Director of Nursing and/or her designee. Necessary revisions to the Care Plans will be made by the MDS Coordinator. Changes in current wounds will be documented by the Wound Care Nurse on the weekly Wound Report.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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 280	Continued From page 5 report revealed on 01/21/15, resident #66 had a newly observed stage II pressure ulcer on right heel which measured 3.0 centimeters (cm) in length by 3.0 cm in width and was 0.1 cm in depth. Resident # 66 had a newly observed stage II pressure ulcer on the plantar area of left foot which measured 1.0 cm in length by 1.0 cm in width and 0.1 cm in depth. A record review of the care plan conference notes for resident #66 dated 01/30/15 revealed plan of care was reviewed. Resident #66 had 2 acquired pressure ulcers and had no other significant changes. A review of resident #66's care plan revealed the following problem: · Onset 11/12/14, resident is at risk for developing a pressure ulcer, related to immobility and incontinence. On 02/05/15 at 7:37 AM an interview was conducted with MDS Coordinator #1 who reviewed resident #66's current care plan in the medical record and verified the care plan did not indicate resident #66 had 2 stage II pressure ulcers with onset date of 1/21/15. MDS Coordinator #1 stated she did not update resident #66's care plan with current stage II pressure ulcers. On 02/05/2015 at 8:08 AM an interview was conducted with the Director of Nursing (DON) who verified that resident #66's current care plan did not indicate resident had 2 stage II pressure ulcers with onset dated 01/21/15. The DON's expectations were that any change in resident condition would be updated on resident's current care plan and physician, family, or responsible party notified of any changes in resident's condition.	F 280	The MDS Coordinator will review the weekly report and revise each Care Plan as necessary. C. The Director of Nursing and/or her designee will conduct audits of the weekly Wound Report and Care Plans for accuracy weekly for four weeks and monthly thereafter for four months to ensure compliance. D. The Quality Assurance Performance Improvement Committee will review for compliance monthly times four months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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 280	Continued From page 6 2. Resident #112 was admitted to the facility 11/23/14 with diagnoses which included a fractured hip and edema. The initial care plan for Resident #112 included a problem area dated 11/23/14, Resident has pressure ulcer left heel stage II related to immobility. Approaches to address this problem area included to complete weekly skin checks. Documentation in the medical record of Resident #112 noted the care plan was reviewed 12/02/14, 12/16/14 and 01/12/15. Review of the pressure ulcer assessments documented in the medical record of Resident #112 noted separate assessments of two pressure ulcer areas; one on the right heel and one on the left heel. The area on the right heel was first addressed 12/03/14 and was last assessed on 02/02/15 as a stage II area. The area on the left heel was first addressed 12/03/14 and was last assessed on 02/02/15 as a stage II with eschar. Though the pressure ulcer assessment specified wounds on both the right and left heels when the care plan was reviewed on 12/16/14 and 01/12/15 the care plan was not updated to reflect the additional wound on the resident's right heel. In an interview on 02/05/15 at 5:00 PM the Minimum Data Set coordinator stated it was an oversight to not update the care plan of Resident #112 to accurately reflect all wounds when it was reviewed on 12/16/14 and 01/12/15.	F 280		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following	F 328		3/5/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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 7 special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to properly secure an oxygen cylinder during transport within the facility for one (1) of three (3) observations (Resident #171): The findings include: Review of Material Safety Data Sheet (MSDS) for the safe handling and transport of portable oxygen cylinders dated 10/16/14, revealed canisters of compressed gas should be handled with care. The cylinders should be protected from physical damage and should not be rolled, dragged or dropped. The safety dated sheet indicated empty cylinders held residue of compressed oxygen and should also be considered dangerous. Movement of the oxygen cylinders should be accomplished when the cylinders are secured in a suitable hand cart. On 02/05/15 at 10:00 AM the Director of Nursing (DON) was observed exiting Resident #171's room carrying a compressed oxygen cylinder up the 200 hall in the direction of the nurses' desk. She was observed carrying the cylinder by a ring on top of the cylinder. No hand cart was used. The DON was observed carrying the cylinder behind the nurses' desk and into a room with a	F 328	A. The oxygen cylinder for resident #171 was secured in the wheelchair holder after being transported to the resident's room on 2/5/15. B. All residents using oxygen were checked to ensure that any oxygen cylinders in use were properly secured on 2/5/15. The employee received education by the Staff Development Coordinator on the proper transport of oxygen cylinders on 2/6/15. All employees will receive education on the proper transport of oxygen cylinders by 3/5/15. The Staff Development Coordinator will provide education through the orientation process for all newly hired employees. C. The Staff Development Coordinator and/or her designee will conduct audits of the proper transport of oxygen cylinders weekly for four weeks and monthly thereafter for four months to ensure compliance. D. The Quality Assurance Performance Improvement Committee will review for compliance monthly times four months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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 8 sign on the door that read "Staff Only" and "Caution Compressed Air". She was observed exiting the room within 60 seconds and carrying an oxygen cylinder by the ring on top of the cylinder, back down the 200 hall. She was observed entering Resident #171's room carrying the oxygen cylinder. No hand cart was used. On 02/05/15 at 10:15 AM an observation was conducted of Resident #171 in her room. She was observed sitting up in a wheelchair with an oxygen cylinder secured to the back of the chair. An empty oxygen transport cart was observed in her room. On 02/05/15 at 10:20 AM an interview was conducted with Nurse Aide #3 (NA#3). She indicated she was present in the room when the exchange of oxygen cylinders occurred. NA #3 acknowledged the DON exchanged the oxygen cylinders on the back of Resident #171's wheelchair. On 02/05/15 at 10:45 AM an interview was conducted with the DON. She stated oxygen cylinders should always be secured and transported within the facility on an oxygen handcart. The DON revealed when empty cylinders are replaced with full cylinders, they should be transported with a hand cart. When the DON was asked if she transported an empty oxygen cylinder from Resident #171's room to the oxygen storage area and returned with a full cylinder without the use of a transport cart, she responded that she did. She indicated she should have used a handcart to transport the oxygen cylinders, but she was in a hurry. On 02/05/15 at 3:00 PM an interview was conducted with the maintenance director. He stated the facility policy indicates oxygen cylinders should be transported with a hand cart.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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	Continued From page 9	F 431		
F 431 SS=E	483.60(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 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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. This REQUIREMENT is not met as evidenced by:	F 431		3/5/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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	Continued From page 10 Based on observations and staff interviews the facility failed to remove expired medications from 3 of 5 medication administration carts. The findings included: 1. Inspection on 02/05/15 at 2:02 PM of the 400 hall medication cart revealed the following expired medications: a) a partially used bottle of Timolol 0.5% eye drops which was stamped as filled on 11/23/14 and labeled as opened on 11/23/14. 2. Inspection on 02/04/15 at 5:04 PM of the combined 500/600 hall medication cart revealed the following expired medications: b) a partially used bottle of Timolol Malfate 0.5% eye drops dated as opened 12/31/14 c) a partially used bottle of Latanoprost 0.005% eye drops dated as opened on 12/08/14 d) a partially used bottle of Timolol 0.15% eye drops which was not dated when opened but was stamped filled on 12/06/15. e) a partially used bottle of Cosopt 2%-0.5% eye drops not labeled with date when opened 3. Inspection on 02/04/15 at 5:05 PM of the 300 hall medication cart revealed the following expired medications: a) an unopened vial of liquid Ondansetron (Zofran) 2mg/ml 4mg in 2ml stamped with manufacturers expired date of August 2014 An interview was conducted on 02/04/15 at 5:04 PM with Nurse # 3 revealed the medications were currently in use and available for any resident receiving those medications. When asked about	F 431	A. All residents that had expired medications were examined by the Medical Director on 2/5/15. All residents were found to be free of any adverse effects. B. The Director of Nursing inspected all medication carts on 2/5/15 for expired medications. All expired medications were removed and replaced with non-expired medications. All Licensed Nurses will be educated on proper medication labeling and removal of expired medications by 3/5/15. The Staff Development Coordinator will provide education through the orientation process for all newly hired Licensed Nurses. C. The Director of Nursing and/or her designee will perform inspections of all medication carts for expired medications weekly for four weeks and monthly thereafter for four months to ensure compliance. D. The Quality Assurance Performance Improvement Committee will review for compliance monthly times four months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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	Continued From page 11	F 431		

the facility's system for checking the medication carts for expired medications, she indicated each nurse administering medications from the cart was responsible for checking for expired medications and for removing them from the cart.

An interview was conducted on 02/04/15 at 5:05 PM with Nurse # 1 revealed the medications were currently in use and available for any resident receiving those medications. When asked about the facility's system for checking the medication carts for expired medications, she indicated each nurse administering medications from the cart was responsible for checking for expired medications and for removing them from the cart.

An interview was conducted on 02/05/15 at 2:02 PM with Nurse # 4 revealed the medications were currently in use and available for any resident receiving those medications. When asked about the facility's system for checking the medication carts for expired medications, she indicated each nurse administering medications from the cart was responsible for checking for expired medications and for removing them from the cart.

An interview was conducted on 02/05/15 at 4:46 PM with the Director of Nursing (DON) about her expectation in regard to expired medications revealed she expected each nurse administering medications to check the medication carts for expired medications and to remove any expired medications from the cart. The DON stated that expired medications should not be available for use on the medication carts. The DON further stated the medications reviewed on the medications carts were expired.

An interview was conducted on 02/05/15 at 5:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	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	Continued From page 12 PM with the Medical Director regarding his expectations in regard to expired medications. He stated that expired medications should not be available for use on the medication carts and should be disposed of according to facility policy and pharmacy recommendations. The medical director explained after review of the medications with the pharmacy that giving eye drops which were expired for glaucoma have the potential for infections and/or eye pressure difficulties.	F 431		