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	345493	A. BUILDING _____ B. WING _____	C 06/10/2016

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HENDERSONVILLE HEALTH AND REHABILITATION	104 COLLEGE DRIVE FLAT ROCK, NC 28731

(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 #56XD11.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility staff stood over residents while assisting them to eat for 2 of 3 Residents reviewed for dignity (Resident #25 and #122). The findings included: 1. Resident #25 was admitted to the facility on 08/29/13. Her diagnoses included hypertension, non-Alzheimer's dementia, and gastroesophageal reflux disease. According to Minimum Data Set (MDS) dated 03/29/16, Resident #25's cognition was coded as severely impaired. The MDS specified Resident #25 as having minimal difficulty in hearing, unclear speech, and required total assistance with all activities of daily living (ADL) care and one person physical assistance with eating. The care plan dated 04/11/16 identified Resident #25 as having impaired physical mobility with self-care deficits that required total assistance with ADL that included feeding. The care plan goal specified the Resident would remain free from immobility complications. Interventions included assisting Resident with all aspects of	F 241	Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. The affected residents will be observed for 3 meals per day for the first week and then 1 meal per week thereafter for 1 month by the charge nurse. Counselling of CNA #5 was completed 6/11/2016. Education of all CNAs as to sitting while feeding was completed 7/5/2016. Observations will be made by Charge nurses, Unit Managers or other designated staff for all meals of dependent residents weekly for 4 weeks, then monthly for 2 months.	7/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/30/2016

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F 241	Continued From page 1 ADL that included feeding on an ongoing daily basis. On 06/07/16 at 1:15 PM, Nurse Aide (NA) #5 was observed delivering a lunch tray to Resident #25's room. NA #5 knocked on the Resident's door before entry. She placed the tray on the bedside table and began to set up the tray while Resident #25 was sitting on her Geri chair. Then, NA #5 started to feed Resident #25 with her left hand. NA #5's right hand was rested on her waist most of the time during the feeding process. Throughout the course of feeding, NA #5 was observed standing and facing Resident #25. The feeding was completed at 1:22 PM. An interview was conducted with NA #5 on 06/07/16 at 1:41 PM. She stated she worked as a nurse aide in the facility for seven years. She recalled feeding training was included as part of the orientation when she started in this facility. She indicated feeding staff were required to sit at the same level with the Resident when feeding Residents in the dining room, but became unsure about feeding Residents in their room. An attempt to interview Resident #25 on 06/10/16 at 3:04 PM was unsuccessful due to her severely impaired cognition. In an interview with Director of Nursing (DON) on 06/10/16 at 3:58 PM, she stated that all the newly hired staff were offered an orientation and preceptorship that ranged from 3-7 days. Feeding training was part of the orientation process. It was her expectation for the feeding staff to sit at the same level with the Resident when performing feeding, regardless of whether the feeding was in the dining room or in the Residents' room. 2. Resident #122 was admitted to the facility on 02/18/11. Her diagnoses included hypertension, aphasia, hemiplegia, depression, and seizure	F 241	The DON/designee will submit audit results will be submitted to the QAPI committee monthly for 3 months to determine the continued need and frequency of monitoring.	

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disorder.
Resident #122's Minimum Data Set (MDS) dated 04/05/16 indicated her cognition as severely impaired. The MDS specified Resident #25 as having unclear speech, impaired vision, and required total assistance with all activities of daily living (ADL) care and one person physical assistance with eating.
A care plan dated 05/02/16 identified Resident #122 as having impaired physical mobility with self-care deficits that related to hemiplegia. Resident #122 required total assistance with all aspects of ADL that included feeding. The care plan goal specified the Resident would remain free from immobility complications. Interventions included assisting Resident with ADL such as eating, toileting, and dressing as needed on an ongoing daily basis.
On 06/07/16 at 1:24 PM, Nurse Aide (NA) #5 was observed delivering a lunch tray to Resident #122's room. NA #5 knocked on the Resident's door prior to entry. She placed the tray on bed table and began to set up the tray while Resident #122 was lying on her bed. NA #5 raised the bed level to about 45 degree angle, then started to feed Resident #122 with her left hand. NA #5's right hand was observed leaning on Resident #122's bed rails most of the time during the feeding process. NA #5 was observed standing and facing Resident #122 throughout the course of feeding that completed at 1:35 PM.
An interview was conducted with NA #5 on 06/07/16 at 1:41 PM. She stated she worked as a nurse aide in the facility for seven years. She recalled feeding training was included as part of the orientation when she started in this facility. She indicated feeding staff were required to sit at the same level with the Resident when feeding Residents in the dining room, but became unsure

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F 241	Continued From page 3 about feeding Residents in their room. An attempt to interview Resident #122 on 06/10/16 at 3:04 PM was unsuccessful due to her severely impaired cognition. In an interview with Director of Nursing (DON) on 06/10/16 at 3:58 PM, she stated that all the newly hired staff were offered an orientation and preceptorship that ranged from 3-7 days. Feeding training was part of the orientation process. It was her expectation for the feeding staff to sit at the same level with the Resident when performing feeding, regardless the feeding was in the dining room or in the Residents' room.	F 241		
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 resident and staff interviews and record reviews the facility failed to provide 3 of 5 sampled residents with the number of showers preferred each week who were reviewed for choices (Residents #71, #319 and #160). The findings included: 1. Resident #71 was admitted to the facility on 11/25/15. Her diagnoses included acute respiratory failure, muscle weakness and difficulty	F 242	The affected residents have been interviewed as to the number of showers preferred each week and staff will comply with an acceptable number on the resident's part. 6/29/16 All residents will be asked by the Social Worker's/Designee as to the number of showers preferred each week and what is acceptable to the resident.	7/8/16

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F 242	Continued From page 4 walking. Resident #71's Minimum Data Set (MDS) dated 05/25/16 coded her as having intact cognition and requiring physical help with one person physical assistance with bathing. Review of Resident #71's current care plan revealed the following "Problem/Need"; "ADL (Activity of Daily Living) Deficits: Impaired physical mobility requiring daily staff assist with ADL's & toileting. Resident fatigues easily". Care plan approaches included; "If able, allow resident choices to promote independence" and "Provide bed mobility, transfers, toileting and bathing & hygiene as needed on an ongoing basis." Review of Resident #71's current care guide revealed she was scheduled to receive two showers per week on Wednesdays and Saturdays during the 7:00 AM to 3:00 PM shift. On 06/07/16 at 4:25 PM, Resident #71 stated during an interview that she did not get to choose how many times a week she received a shower. The resident stated she received a shower twice a week on Wednesdays and Saturdays. The resident specified that she would like to receive four showers per week because she sweats, but staff had never asked her if she wanted more than two showers per week. During a follow up interview on 06/08/16 at 4:05 PM, Resident #71 stated she would like to receive four showers per week on Mondays, Wednesdays, Fridays and Saturdays. The resident stated she had asked staff at times to provide her with more than two showers per week, but she was told they could only provide	F 242	Staff will be educated as to observing the resident's preferred number of showers each week. Each new admission will be informed of facility practice and then ask if that is acceptable. The Social Workers will review residents shower records weekly for 12 weeks to ensure resident requests are being honored. Results of the audits will be reviewed by the QAPI committee monthly for 3 months to ensure compliance and determine continued need and frequency of monitoring.	

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her with two showers per week.

Nurse Aide (NA) #1, who provided care to Resident #71, was interviewed on 06/10/16 at 10:30 AM. NA #1 stated the resident shower schedule was posted in the clean utility room and Resident #71 was scheduled to receive two showers per on Wednesdays and Saturdays during the 7:00 AM to 3:00 PM shift. NA #1 stated the resident required assistance with showers and is always ready to receive her scheduled showers. NA #1 explained to her knowledge residents were offered two showers per week and if a resident requested additional showers staff would do the best they could to try to honor the resident's request.

Interview with the Director of Nurses (DON) on 06/10/16 at 11:15 AM revealed on admission to the facility residents were informed they would receive two showers per week. The DON stated residents were not informed that they could receive more than two scheduled showers per week if they preferred. The DON explained that staff would begin to inform residents at the time of admission that more than two scheduled showers per week could be requested to ensure they are aware that a request for additional scheduled showers was permissible. The DON stated when a resident requested to receive more than two showers per week the staff should accommodate this request.

Interview with the facility's Admissions Coordinator on 06/10/16 at 2:25 PM, revealed residents and their family members were informed during the admission process that residents received two scheduled showers per week. The Admissions Coordinator stated that

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residents were not asked about their shower preferences or informed that they could request to receive more than two scheduled showers per week.

2. Resident #319 was admitted to the facility on 06/02/16. Her diagnoses included presence of aortocoronary bypass graft and congestive heart failure.

Review of Resident #319's Admission Nursing Evaluation dated 06/02/16 revealed she was alert and oriented, able to understand others and required assistance with bathing.

Review of Resident #319's current care guide revealed she was to receive two showers per week on Tuesdays and Fridays during the 7:00 AM to 3:00 PM shift.

On 06/07/16 at 3:53 PM, Resident #319 stated during an interview that she did not get to choose how many times a week she received a shower. The resident stated she was a new admission to the facility and received two scheduled showers per week. The resident specified she would prefer to receive more than two showers per week, but no one had ever offered to provide her with more showers. The resident stated that her preference would be to receive four showers per week or a shower every day if possible. During a follow up interview on 06/09/16 at 11:36 AM, Resident #319 stated she was admitted to the facility last week and no one provided her with a choice about how many showers she could receive each week. The resident explained she was informed by staff that she would receive two showers per week and staff never asked her about her shower preferences. The resident

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stated, "It would be nice to receive four showers per week."

Interview with the Director of Nurses (DON) on 06/10/16 at 11:15 AM revealed on admission to the facility residents were informed they would receive two showers per week. The DON stated residents were not informed that they could receive more than two scheduled showers per week if they preferred. The DON explained that staff would begin to inform residents at the time of admission that more than two scheduled showers per week could be requested to ensure they are aware that a request for additional scheduled showers was permissible. The DON stated when a resident requested to receive more than two showers per week the staff should accommodate this request.

Nurse Aide (NA) #2, who provided care to Resident #319, was interviewed on 06/10/16 at 11:57 AM. NA #2 stated Resident #319 had been at the facility for about a week and required standby assistance with showers and the hall's shower schedule was posted in the hallway's linen closet. Review of the shower schedule revealed Resident #319 was scheduled to receive showers twice a week on Tuesdays and Fridays. NA #2 stated if a resident requested more than two showers per week staff would try to accommodate these requests if possible. NA #2 was unaware of any residents who currently received more than two scheduled showers per week.

Interview with the facility's Admissions Coordinator on 06/10/16 at 2:25 PM, revealed residents and their family members were informed during the admission process that

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F 242	Continued From page 8 residents received two scheduled showers per week. The Admissions Coordinator stated that residents were not asked about their shower preferences or informed that they could request to receive more than two scheduled showers per week. 3. Resident #160 was admitted to the facility on 03/09/16 with diagnoses which included acute muscle weakness and depression. Resident #160's Quarterly Minimum Data Set (MDS) dated 05/22/16 indicated his cognition was intact. The MDS specified Resident #160 as having moderate difficulty in hearing, impaired vision, and required extensive staff assistance with personal hygiene and one person physical assistance with bathing. The care plan dated 03/29/16, identified Resident #160 as having activities of daily living (ADL) deficits that required extensive assistance with ADL which included bathing. Interventions included providing Resident choices to promote independence. Review of Resident #160's bath roster revealed he was scheduled to receive showers twice weekly on Monday and Thursday. In an interview on 06/07/16 at 3:38 PM, Resident #160 stated he had received showers twice per week in the facility but preferred to have showers once every other day. Resident #160 specified that the admission coordinator did not ask him about his shower frequency preferences during the admission process. In addition, he was told he would get showers twice a week during admission. According to Resident #160, when he asked a nurse aide for additional showers, he had	F 242		

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F 242	Continued From page 9 been told he could have only two showers per week. Interview with Nurse Aide #4 on 06/10/16 at 10:41 AM revealed Resident #160 received showers twice weekly based on a schedule determined by room number. She reported Resident #160's wife had requested once to have additional showers for her husband. Nurse Aide #4 stated she would normally accommodate additional shower requests if her busy schedule permitted. On 06/10/16 at 11:42 AM, the Admission Coordinator was interviewed and explained that she had informed admitting Residents or families to expect to be offered two showers weekly. She added the admission process did not include informing admitting Residents or families of a choice in frequency of showers. In an interview conducted on 06/10/16 at 3:09 PM, the Director of Nursing (DON) stated that residents were allowed to make specific requests for shower frequency. The facility would accommodate those requests to the fullest extent. She expected admission staff to inform Residents or family of their privilege to request shower frequency upon admission. The DON stated she was not aware of Resident #160's preference to have showers once every other day. It was her expectation for the nurse aides to honor Residents' shower frequency preferences and communicate residents' preferences with the management.	F 242		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		7/8/16

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F 428	Continued From page 10 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacist interviews, the facility failed to follow-up with the consultant pharmacist's recommendations for 1 of 5 sampled residents (Resident #160) reviewed for unnecessary medications. The findings included: Resident #160 was admitted to the facility on 03/09/16 with diagnoses which included diabetes mellitus (DM), depression, and anxiety disorder. The quarterly Minimum Data Set (MDS) dated 05/22/16 coded Resident #160 as cognitively intact. The MDS specified Resident #160 as having moderate difficulty in hearing, impaired vision, and required extensive staff assistance with activities of daily living (ADL). The care plan dated 03/29/16 identified Resident #160 as having a potential risk for complication secondary to DM. The care plan goal specified the Resident would remain free from complications related to DM. Interventions included continuous monitoring for signs and symptoms of hypoglycemia and/or hyperglycemia. In another care plan dated 03/29/16, Resident #160 was coded as having a potential risk of drug toxicity due to psychotropic drug usage. The care plan goal specified the Resident would remain free of side effects of psychotropic medications. Interventions included continuous monitoring, documenting, and	F 428	The affected resident's pharmacy recommendations were followed up on with the attending physician. 6/9, 6/10, 6/27. The monthly pharmacy report will be reviewed for timeliness of the physicians' response by the DON/Designee. If the physician does not respond to the pharmacist recommendation timely, the Medical Director/designee will review the recommendation and respond. The DON/designee will review the pharmacy report monthly to ensure that all recommendations have been reviewed and responded to by the physician prior to the time of the next pharmacy review. The DON/designee will report the timeliness of completion of the pharmacy recommendations monthly x 3 to ensure compliance and determine continued need and frequency of monitoring.	

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reporting of behavior abnormality to physician as needed.
A review of the facility consultant pharmacist monthly medication regimen review (MRR) revealed the MRRs were conducted once each month since Resident #160's admission. The consultant pharmacist's monthly MRR dated 04/21/16 indicated he had documented four recommendations to the physician/Director of Nursing (DON) for Resident #160. Review of the "Consultant Pharmacist Communication to Physician" records dated 04/21/16 revealed the following recommendations:
· Reevaluated the continued need for Zyprexa or consider a trial discontinuation.
· Considered increasing Aggrenox to once every 12 hours instead of once every morning to comply with manufacturer recommendations.
· Considered adding Lisinopril 2.5 milligram (mg) once daily as appropriate for Resident's DM.
· Considered conversion of sliding scale to routine basal-bolus regimen of Lantus, or increased the dosage of glimepiride to eliminate multiple finger sticks daily.
All the above recommendations were not signed and dated by the physician when Resident #160's medical records was reviewed on 06/09/16.
Further review of Resident #160's medical records revealed there was no documentation to indicate the consultant pharmacist's recommendations had been addressed or acted on by the physician or follow-up had been done by the DON during the 7+ weeks since the consultant pharmacist's initial recommendations were made on 04/21/16.
On 06/09/16 at 5:18 PM, an interview was conducted with the DON. She stated the physician had only one Resident in this facility. Normally, after she received the consultant

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pharmacist's recommendations in hard copy, she would send the hard copies to the physician's office the following day. For the month of April 2016, she recalled the consultant pharmacist's recommendations had been delivered to the physician's office on 04/22/16.

In an interview conducted on 06/09/16 at 6:12 PM, the consultant pharmacist stated that he would normally spend 1-2 hours with DON and Administrator to go over his findings and recommendations after the completion of monthly MRR. He would then print the recommendations in hard copies and handed it to the DON. The DON was responsible to transmit the recommendations to the respective physicians in a timely manner. The consultant pharmacist noted if he did not receive a response from the physician when he came back for the next MRR, he would resend the recommendation(s). He added the recommendations for Resident #160 on 04/21/16 were with the physician.

Review of MRR dated 05/19/16 indicated the consultant pharmacist did resend one (Recommendation regarding the continued need of Zyprexa) of the four recommendations from 04/21/16 but failed to follow-up with the other three recommendations.

On 06/10/16 at 3:09 PM, an attempt to conduct a phone interview with the physician was unsuccessful. The physician was unavailable and did not respond to the phone message.

In a subsequent interview conducted on 06/10/16 at 3:58 PM, the DON specified she should have contacted the Medical Director in a timely manner should a similar scenario occur again. In addition, she would do the follow-up with the consultant pharmacist's recommendations if it had not been heard from physician for over one month.