STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 6OIT11.	F 000		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and store personal care items in a shared bathroom (room # 301) on 1 of 6 halls. Findings included: On 7/17/17 at 11:56 AM a urinal labeled 301A, 2 urinals not labeled, one bedpan labeled 301A, and one specimen hat not labeled were observed on top of the bathroom cabinet in room # 301. All items were not covered or bagged. On 7/18/17 at 8:37 AM a urinal labeled 301A, 2 urinals not labeled, one bedpan labeled 301A, and one specimen hat not labeled were observed on top of the bathroom cabinet in room # 301. All items were not covered or bagged. On 7/19/17 at 9:45 AM a urinal labeled 301A, 2 urinals not labeled, one bedpan labeled 301A, and one specimen hat not labeled were observed on top of the bathroom cabinet in room # 301. All items were not covered or bagged. On 7/19/17 at 9:45 AM an interview with Resident # 74 indicated he did not know if the items in the bathroom of 301A were his or his roommates and he stated he did not know why the items were on	F 253	On 7/19/17 3 urinals, a specimen hat and a bed pan were found to be unlabeled or bagged. The observed issue was corrected immediately by the ADON, who threw the urinals, bedpan and specimen hat in the trash. Infection Control In-services were initiated immediately by the DON on 7/19/17 and will be completed on 08/14/2017 with nursing/maintenance/housekeeping/Administrative Staff and Department Heads to inform them of the proper procedure for labeling and bagging personal care items. Personal care items will be labeled and bagged if appropriate per resident preference. Staff conducted a 100% audit of all resident rooms on 7/19/17 and no other issues were found. Administrative staff and department heads will be assigned daily room round audit tools and will report findings to the administrator or DON Monday-Friday. Room rounds will be implemented on 8/11/17 and will be conducted daily for 1 month and then monthly for 3 months.	8/11/17

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

Electronically Signed | 08/11/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 253	Continued From page 1 top of the cabinet. On 7/19/17 at 9:49 AM an interview with Nurse aide # 1 stated urinals and bed pans were supposed to be labeled with the resident's name or room number, covered with Ziploc bags, and stored in the bathroom cabinet or hung on the bathroom railing. Nurse aide # 1 indicated she did not know why the items were stored on top of the bathroom cabinet in room # 301 and all items should have been labeled and covered. The nurse aide also stated she did not know which resident the items belonged to. The nurse aide further indicated the resident in A bed was total care. On 7/19/17 at 9:56 AM an interview with the Assistant Director of Nursing (ADON) stated the items in room # 301 were not stored properly and her expectations were for the items to be labeled and bagged appropriately. The ADON stated the staff was supposed to make rounds daily to make sure items were covered and labeled. The ADON indicated she did not know why the items were stored on top of the bathroom cabinet. The ADON also stated the resident in A bed was total care and incontinent at times. The ADON further stated she did not know how long the items had been in the bathroom or who the items belonged to so she was going to throw the items in the trash. On 7/19/17 at 11:20 AM an interview with the Administrator revealed his expectations were for the personal care items to be labeled and stored in the cabinet. On 7/19/17 at 11:26 AM an interview with the Regional Manager stated his expectations were	F 253	Results from monitoring this deficient practice will be reviewed by the administrator or DON Monday-Friday x 4 weeks, then weekly x 4 weeks, then monthly x 1 and implement changes in monitoring frequency based on findings. The Quality Assurance team will then determine the continued need for monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 253	Continued From page 2 for the personal items to be bagged and labeled.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct	F 272		8/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 272	Continued From page 3 observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to provide a comprehensive Care Area Assessment related to psychotropic drug use for 1 of 18 sampled residents (Resident # 206) Findings included: Resident # 206 was admitted to the facility on 10/22/15 with diagnoses that included depression and anxiety. Review of the annual Minimum Data Set (MDS) dated 10/26/16 indicated Resident # 206 was cognitively intact and received antianxiety and antidepressant medication during the seven day look back prior to the 10/26/16 assessment. The psychotropic Care Area Assessment (CAA) summary dated 11/7/16 for Resident # 206 stated, "Resident takes Escitalopram 20 mg for depression, Alprazolam for anxiety. Active current diagnoses are: recent surgical wound on right shin, reflux, diabetes, edema, HTN, depression, diarrhea, pain, occasional nausea, vomiting, wheezing, muscle spasms, anxiety, anemia, low magnesium. Analysis of findings: Resident has	F 272	On 7/20/17 it was found that the facility failed to provide a comprehensive care area assessment. MDS coordinators were in serviced by the DON on 7/21/17 and 8/1/17 on comprehensive assessments. The Care area assessment that was found to be non-compliant was corrected on 7/21/17. The MDS department attended an educational MDS conference on 8/7/17 provided by Myers and Stauffers. A comprehensive audit of all resident care area assessments was completed on 8/11/2017 by the MDS nurses and the Regional Clinical Manager and modifications were made as identified. A monthly thirty percent audit of all care area assessments will be completed x 3 months, by the interdisciplinary care plan members and results will be reviewed by the administrator. The tool that will be used will be the Comprehensive Assessment audit tool.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 272	Continued From page 4 diagnoses of anxiety and depression. She takes an antidepressant and an antianxiety medication." The CAA dated 11/7/16 did not include a comprehensive analysis of the description of the problem, the resident's strengths and weaknesses, the causes and contributing factors and the risk factors relating to the use and need of psychotropic medication. The CAA did not include input from resident # 206 or a family member. The CAA did not include findings supporting the decision to proceed to care plan. On 7/20/17 at 10:38 AM MDS Nurse # 1 indicated the CAA was supposed to state a summary of the resident and paint a picture of the resident. MDS Nurse # 1 stated the psychotropic CAA for Resident # 206 was basic and did not paint a picture of the resident. On 7/20/17 at 10:44 AM MDS Nurse # 2 stated the CAA for Resident # 206 did not analyze the resident and was not supportive for the overall plan of care for the resident. MDS Nurse # 2 also stated the CAA was not descriptive of the resident. MDS Nurses # 2 further stated she had educated the previous MDS nurse about her CAAs not being supportive. On 7/20/17 at 11:24 AM The Regional Director stated he expected for the CAA to summarize the resident and for any issues triggered by the MDS to be care planned.	F 272	The monthly audits will be reviewed by the Quality Assurance team to determine continued frequency of monitoring.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident	F 279		8/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 279	Continued From page 5 assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 279	Continued From page 6 (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan for psychotropic medication use for 1 of 5 residents sampled for unnecessary medication. (Resident # 206). Findings included: Resident # 206 was admitted to the facility on 10/22/15 with diagnoses of depression and anxiety. Review of the annual Minimum Data Set (MDS) dated 10/26/16 indicated Resident # 206 was cognitively intact and received antianxiety and antidepressant medication during the seven day look back prior to the 10/26/16 assessment. The Care Area Assessment (CAA) indicated the use of antipsychotic medications triggered for a care plan to be completed. The CAA summary also	F 279	All MDS coordinators were in serviced by the DON on 7/21/17 and 8/1/17 on the development of comprehensive care plans. The comprehensive care plan for resident #206 was corrected on 7/21/17. The MDS department attended an educational MDS conference on 8/7/17 provided by Myers and Stauffers. A comprehensive audit of all resident care plans was accomplished on 8/11/17 by the Regional Clinical Manager and MDS nurses and modifications were made as identified. The Interdisciplinary care team will do a monthly 30 percent audit of all care plans x 3 months and results will be reviewed by the administrator. The tool that will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 279	Continued From page 7 indicated that a care plan would be developed for the care area. Review of Resident # 206's current care plan last updated on 4/26/17 revealed no care plan for psychotropic medication use. Review of the April 2017 medication record revealed Resident #206 received antianxiety and antidepressant medication. On 7/20/17 at 10:44 AM MDS Nurse # 2 stated it was the MDS Nurse's responsibility to complete the care plans. MDS Nurse # 2 reviewed the care plan for resident # 206 and verified there was no care plan for the use of antipsychotic medication. MDS Nurse # 2 stated the psychotropic medication CAA triggered to proceed to care plan on the annual MDS dated 10/26/16. MDS Nurse # 2 indicated a psychotropic care plan should have been developed for Resident #206. On 7/20/17 at 11:24 AM The Regional Director stated his expectations were for any issues triggered by the MDS to be brought forward to the care plan and reviewed and updated as needed.	F 279	used will be call the Comprehensive Care Plan Audit tool. The monthly audits will be reviewed by the Quality Assurance team to determine continued frequency of monitoring.	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 371		8/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 371	Continued From page 8 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, review of records, and staff interviews the facility failed to 1) maintain freezer temperatures at 0 degrees Fahrenheit (F.), 2) ensure that all dishes stored ready for use were completely dry with no water on the surfaces where food was to be placed and 3) ensure all fly activity measures were effective to prevent fly activity over the meal service line in the kitchen. The findings included: 1. During the initial tour of the kitchen on 07/17/17 at 10:00 am conducted with the Dietary Manager (DM), the walk in freezer temperature was 22 degrees F. The DM stated the freezer was "cycling through the defrost mode." When asked if the freezer was defrosting, the DM stated no, but the freezer cycles and the fans turn off and the temperature drops as if going into defrost mode. The DM suggested to come back when the freezer is not cycling through defrost and the	F 371	Service engineers were called and replaced the thermostat on 7/17/17. Service engineers were called back out to inspect the freezer and replaced the condensing motor on 7/18/17. Freezer was still fluctuating in temperature therefore a freezer truck was delivered on the evening of 7/19/17 and all food was transferred to freezer truck and has remained until 8/7/17. On 8/4/17 the entire freezer unit was replaced. New freezer unit was tested for a period of 3 days to insure proper freezing temperatures. All food was transferred back to the walk-in freezer on 8/7/17. On 7/19/17 eco lab was called to inspect dish machine. Eco lab found that the rinse agent was not properly dispersing. The mother board on the rinse agent was replaced and no further issues were found.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 371	Continued From page 9 fans are on to re-check the temperature. There were no visible signs of any of the items in the freezer defrosting and food items were hard to touch. A second observation of the freezer on 07/19/17 at 10:45 am revealed the freezer temperature again at 22 degrees F. The DM stated she had talked with the Maintenance Director (MD) yesterday and he had called a repairman in to look at the freezer. The repairman changed the thermostat on the freezer and stated that it should work correctly now. There were no visible signs of any of the food items in the freezer defrosting and items were hard to touch. A third observation of the freezer on 07/19/17 at 4:21 pm revealed the freezer with the fans on and the temperature at 10 degrees F. Dietary Aide #2 stated to the DM "I just checked the temperature and it was fine." The DM stated she did not understand why the freezer was not working that it had been working up until this week. There were no visible signs of any of the items in the freezer defrosting and food items were hard to touch. The DM provided the walk-in freezer's temperature logs for the months of June 2017 and July 2017. Review of the June 2017 temperature log revealed there were 26 days out of 30 days, the freezer's morning temperature was documented as not operating at 0 degrees F. or below. Further review of the June 2017 freezer's temperature log revealed 25 days out of 30 days, when the freezer's evening temperature was documented as not operating at 0 degrees F. or below. Review of the walk-in freezer's July 2017	F 371	On 7/19/17 the maintenance director was informed of the flies in the kitchen. He inspected the fly traps and found that they were in working condition. An in-service was held by the dietary director on 7/19/17 to educate the dietary staff on temperature recording and reporting. On 8/4/17 the entire freezer unit was replaced. New freezer unit was tested for a period of 3 days to insure proper freezing temperatures. All food was transferred back to the walk-in freezer on 8/7/17. This in-service also included proper handling and storage of wet dishes. Staff was in serviced on pest control in the kitchen by the dietary director. In the future when pests are seen in the kitchen they are to inform the dietary director. The dietary director will then contact maintenance to have the pest control service come to investigate. Assistant dietary manager, Dining Services director or Designee will check refrigerator / freezer temperatures and sign temperature log on a daily basis. Assistant dietary manager, Dining Services director or Designee will check daily for wet dishes and will sign off daily for one month. Weekly spot checks will then be done for 2 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 371	Continued From page 10 temperature log revealed from July 1 through July 18, there was only one morning the freezer's temperature was documented at 0 degrees F. or below and none of the evening recorded temperatures were documented at 0 degrees F. or below. An interview with the DM on 07/19/17 at 4:13 pm revealed that she was not aware the temperatures were not in the expected range and the staff had not reported the problem to her. She stated that she reviews the temperatures daily but thought the freezer was cycling when the temperatures were above or below 0 degrees F. An interview with the Administrator and Dietary manager at 4:15 pm revealed they were working with maintenance and the repairman to figure out the problem with the freezer. The administrator stated he was not aware the freezer had not been at the correct temperature since the beginning of June 2017 and stated they were trying to get it resolved today. The Administrator and DM stated they would in-service all the staff today prior to them leaving work to make sure they were aware the freezer temperature must be at 0 degrees F or below and if not they are to report it to the DM immediately. A fourth observation of the freezer on 07/20/17 at 7:55 am revealed it had been cleaned out and all items in the freezer had been placed in a freezer truck they had ordered because the temperature when they checked it earlier was 11 degrees F and the temperature now was 40 degrees F. An interview with the Administrator and DM on 07/20/17 at 8:15 am revealed they could not keep the temperature constant so they thought it best	F 371	Three additional bug lights have been purchased and will be placed at each dining room door entrance to the kitchen and one additional one at the door inside the kitchen. Assistant dietary manager or Dining Services director will monitor the kitchen daily x 4 weeks, then weekly x 8. The freezer, wet dish and pest control audit tool will be reviewed by the administrator/DON Monday-Friday x 4 weeks, then weekly x 8 weeks and implement changes in monitoring frequency based on findings. The Quality Assurance team will then determine the continued need for monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 371	Continued From page 11	F 371		

to just order a freezer truck and move everything out into the truck until the freezer is either repaired or replaced. The Administrator stated his expectation was for the freezer to be maintained within the appropriate temperature of zero degrees F. or below.

2. During an observation on 07/19/17 at 11:00 am of meals being plated from the kitchen's meal service bar, 25 out of approximately 150 plates, 2 crates of large bowls which contained approximately 48 bowls and 1 crate of small bowls which contained approximately 36 small bowls were wet on the inside. The plates were stored in the warmer, the bowls were in crates and had been placed by the server to be used for the lunch meal. The dietary aide started to plate one of the wet plates and was stopped by the DM and it was pointed out to her the plate was wet and could not be used. She started setting aside the plates and the DM took them back over to the dishwasher to re-clean them. The DM then checked the bowls and took those back over to the dishwasher to clean. The plate covers were also wet and 15 of those were sent back for water inside the lid. The DM stated she did not know why the dishes were not dry because they had been through the dishwasher and should be dry. She stated the plate covers should have been dry also because they had been in the drying racks. She stated it may have been due to the high humidity in the kitchen.

During the resident's lunch service there were 3 bowls sent back to be re-washed that were returned to the meal service line for use and still had water on the inside of them.

An interview with Dietary Aide # 1 on 07/19/17 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 371	Continued From page 12	F 371		

12:08 pm revealed this was not the first time the dishes for service had been wet. She stated they had used wet dishes to plate the resident's food at previous meals.

An interview with Dietary Aide #2 on 07/19/17 at 12:10 pm revealed he was responsible for the dishes being washed and stored for drying. He stated he was not aware of another time the dishes for service had been wet. He stated if they were wet it had not been reported to him.

An interview with the DM and Administrator on 07/19/17 at 4:15 pm revealed the problem with the dishes had to be related to the concentration of chemicals in the rinsing cycle. The Administrator stated they had contacted the company and they were sending a technician out to check the chemical levels. The Administrator stated his expectation was for the dishes to come out of the dishwasher dry and for the residents to be served on clean and dry dishes.

3. During the lunch meal service on 07/19/17 at 11:30 am, an observation was made in the kitchen of 3 different flies flying above the meal service bar. The flies were flying above the food and pitching on the light cord hanging above the service bar throughout the entire meal service.

Observation of the kitchen on 07/19/17 at 12:45 pm revealed there was an electronic fly/insect trap in the kitchen hanging from the ceiling for flies and insects.

An interview with the Dietary Manager (DM) on 07/19/17 at 12:50 pm revealed that she was aware of the flies above the service line during the lunch meal service of 07/19/17 and stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345493	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 371	Continued From page 13 that she was not sure why the electronic fly/insect trap had not gotten the flies. The trap was located in the corner at the back entry of the kitchen. There were no observed points of entry at the back door of the kitchen. She stated that she would talk with the Maintenance Director (MD) and have him check the electronic fly/insect trap to make sure it was operating properly. An interview with the Administrator on 07/19/17 at 2:00 pm revealed he was not aware of the fly activity in the kitchen. The Administrator stated he would meet with the Maintenance Director and make sure the electronic fly/insect traps in the kitchen and dining areas were working properly. He stated his expectation was there be no fly activity in the kitchen and especially not over the food service bar.	F 371		