PRINTED: 02/13/2025 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345312	B. WING			C
NAME OF PI	ROVIDER OR SUPPLIER	343312		STREET ADDRESS, CITY, STATE, ZIP CODE	ı	02/05/2025
THE GREE	ENS AT HENDERSONVIL	LE		1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	00		
	to conduct an unanno investigation. The su 01/29/25 and 01/30/2 was obtained offsite of Therefore, the exit date Event ID# LS4K11. The following intakes NC00226516 and NC allegations resulted in Past-noncompliance CFR 483.12 at tag F6 of (J). CFR 483.12 at tag F6 of (J). The tags F604 and F6	rvey team was onsite 5. Additional information on 01/31/25 and 02/05/25. Ite was changed to 02/05/25. were investigated: 00226555. 2 of 2 complaint on deficiency.				
F 604 SS=J	CFR(s): 483.10(e)(1). §483.10(e) Respect a	Physical Restraints , 483.12(a)(2) and Dignity. ght to be treated with respect	F 6	04		
	physical or chemical purposes of discipline required to treat the reconsistent with §483.	ht to be free from any restraints imposed for e or convenience, and not esident's medical symptoms, 12(a)(2).				
		right to be free from abuse,				
_ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Electronically Signed 02/13/2025

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345312	B. WING			l '	05/ 2025
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE		18	TREET ADDRESS, CITY, STATE, ZIP CODE 170 PISGAH DRIVE ENDERSONVILLE, NC 28791	<u> </u>	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	and exploitation as de includes but is not limicorporal punishment, any physical or chemitreat the resident's missingly services of the symptoms. When the indicated, the facility alternative for the lead ocument ongoing restraints. This REQUIREMENT by: Based on record revireview, and staff, Law Wound Nurse Practiti interviews, the facility vulnerable resident's restraints when Resident's restraints when Resident's restraints when Resident's restraints when Resident's resident #1 was obseach hand that were wrapped around each tourniquets (device of situations to apply preto stop blood flow) on controlled manner. He than normal through the	efined in this subpart. This sited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- that the resident is free nical restraints imposed for e or convenience and that eat the resident's medical use of restraints is must use the least restrictive st amount of time and evaluation of the need for is not met as evidenced iew, photographic evidence of Enforcement Officer, oner, and Medical Doctor failed to protect a right to be free from physical dent #1 was found with a hand and held in place by d around each wrist for 1 of for restraints (Resident #1).	F	604	Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345312	B. WING		C 02/05/2025	
	ROVIDER OR SUPPLIER ENS AT HENDERSONVI	LLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 604	hand was edematous an accumulation of fl and bright red in app several blisters on th fluid filled blister in the some drainage and a indentation left on the wrist. Resident #1 w NP on 01/27/25 who of Resident #1's right centimeters (cm) by wound treatment to be reasonable person of deficiency as a reasonable person of deficiency as a reasonable person or using their hands from rubber bands w wrists to hold the soor Findings included: Resident #1 was add 07/31/24 with diagnor disease, dementia at chronic disease that system). The quarterly Minimulassessment dated 1: #1 with severe impair required total staff as tasks, mobility and trimpairment in her up displayed no behavior MDS noted Resident no unhealed pressur	ands. Resident #1's right is (abnormally swollen due to uid in the bodies tissues) earance. There were is top of the hand, a large is palm of the hand with a red ligature (visible is skin) mark around the right is evaluated by the Wound noted the blister on the palm it hand measured 17 20 cm by 0 cm and ordered is papilied daily. The oncept was applied to this onable person would not is placed on their hands in freely moving their fingers and would experience pain rapped tightly around their cites in place. Initted to the facility on is the included Alzheimer's ind multiple sclerosis (a affects the central nervous in Data Set (MDS) 1/07/24 assessed Resident in cognition. She is istance for all self-care	F 604			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		345312	B. WING _			C 02/05/2025
	ROVIDER OR SUPPLIER	LLE		STREET ADDRESS, CITY, STATE, ZIP COL 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	<u> </u>	02/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	
F 604	Resident #1 had a be coprophagy (eating fincluded for staff to in attention, monitor an needed. The care plintervention to apply to her hands. Review of the physic revealed no order for of socks or rubber bit wrists. A Situation, Background Response (SBAR) so Nurse #1 on 01/27/2 part, Resident #1 has protection from scrat socks were removed Resident #1's hands (clear, watery liquid) The on-call provider (DON) were notified. A telephone interview #1 on 01/29/25 at 1:4 she was employed be was assigned to prove Sunday 01/26/25 to 1 hours of 11:00 PM to around 12:30 AM, No her know that Reside on her hands, rubber and her hands were she immediately were	ed on 11/14/24 revealed ehavior problem of	F 6	04		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345312	B. WING			C 2/05/2025	
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STA 1870 PISGAH DRIVE HENDERSONVILLE, NC	TE, ZIP CODE	210012020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
F 604	stated she cut the sexident #1's left had red and her left blistered. Nurse #1 on-call provider and phone call from the ahead and provided right hand. Nurse #Resident #1's medicany physician order her hands and there care plan either. Nowould play in her fecould only assume placed the socks are however, that was retypically used. She socks or rubber bar how long they had a stated during her as not display signs or just received her some dication) earlier no one had mention socks and rubber be #1's hands until it we NA #1. A telephone interview Aide (NA) #1 on 01, revealed she was everified she was as #1's care on Sunda 01/27/25 during the AM. NA #1 recalled incontinence rounds	ge 4 #1's right hand and Nurse #1 ock and rubber bands off and. Nurse #1 recalled hand was swollen, blistered hand was swollen but not notified the DON, called the while waiting for a return on-call provider, she went the treatment to Resident #1's the stated she looked through cal records and did not see is for socks to be placed on the was no intervention in her turse #1 explained Resident #1 ces on occasion and she that was why someone had and rubber bands on her hands; that was why someone had and rubber bands on her hands; that on Resident #1's hands or the provide had be an an intervention the facility did not know who applied the ands on Resident #1 did symptoms of pain as she had heduled morphine (pain that evening. Nurse #1 stated the anything to her about the ands observed on Resident that evening to her about the ands observed on Resident that eve	F	604			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILD	NG		Ι,	c
		345312	B. WING				05/2025
NAME OF P	ROVIDER OR SUPPLIER	•		S1	FREET ADDRESS, CITY, STATE, ZIP CODE		
THE ODE	ENG AT HENDERGONN			18	370 PISGAH DRIVE		
THE GRE	ENS AT HENDERSONV	ILLE		Н	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	the covers she observed Resident #1's hands by rubber bands. No rubber bands had be #1's wrists at least it tell Resident #1's hat the socks on becautightly against the socks on becautightly against the sock to cut them in order Resident #1's hands with the right hand aremoved, she immeright hand was very and wrist was bright were red marks around with the right hand and a palm of her right has tated she immedia when Nurse #1 cam Resident #1 she insubber bands and sercalled Resident # but less red in appeate she recalled and the Resident #1's left whad been. NA #1 wand rubber bands or recalled staff mentic #1 messed with her never witnessed Rebehavior. NA #1 states.	ge 5 ent #1's room and pulled back erved socks on both of a that were being held in place IA #1 stated she thought the een wrapped around Resident wice. She stated she could ands were swollen even with se her hands were pressed bocks and looked much bigger ve been. She explained as were so large, she was not as or rubber bands off and had to remove them from a. NA #1 stated she started and once the sock was diately noticed Resident #1's swollen, the skin of her hand at red in appearance and there and her wrist where the een that started to bruise. In disease, which is a large blister covering the modern that were leaking. NA #1 tely informed Nurse #1 and the to the room to assess structed NA #1 to cut the lock off the left hand. NA #1 the left hand was also swollen arance with no blisters that the ever red marks around the rist where the rubber bands has not sure who put the socks in Resident #1's hands but oning in the past that Resident #1 display that type of ated if Resident #1 had as when she provided her care,	F	604			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345312	B. WING		C 02/05/2025
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	, 32.00.2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE COMPLETION
F 604	her hands to deter to be considered a research to be considered and to be considered and be considered and be complace/secure socks tightly on Resident a extremities that course to be considered and be complace/secure socks tightly on Resident a extremities that course to be considered and the consid	socks and/or rubber bands on the behavior because it would straint. Intitioner (NP) progress note baled in part, Resident #1 was and wound consult. The cility staff reported Resident for on the right hand that was sing secured on her hands. It is not caused by heat or exight hand with partial the skin between the top and the skin between the	F 60	,	
	the dorsal (part of the are located) side of on the palm of her habitaters looked like with the damage from the superficial and he let them heal naturally.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345312	B. WING			C 2/05/2025	
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE		STREET ADDRESS, CITY, STATE, ZIP CODI 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 604	and swelling. A Medical Doctor (MI 01/27/25 read in part evaluate blisters on hoted socks were plawith rubber bands, to scratching certain pasometimes gathered rubber band was much was unclear exactly had been on Resider socks were removed amount of blisters no MD assessment revehand had large, raise (palm) surface and dook indurated (hardeskin) and there was nor skin discoloration. vascularity (blood flow moving all fingers with some non-pitting edearea and the rubber bwist was barely notic blisters with alcohol, puncture the blisters fluid drained from the cream and gauze dre Resident #1's right had a small blister muthe thenar eminence base of the thumb) winduration noted. Reall the fingers of the I had good distal vasci	D) progress note dated, Resident #1 was seen to prevent Resident #1 from the right change the rubber bands of the rubber bands	F 60	04			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
		245240	B WING			С	
		345312	B. WING _		0)2/05/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	TE, ZIP CODE		
THE CDE	ENS AT HENDERSON	IVII I E		1870 PISGAH DRIVE			
IIIL GILL	LING AT TILINDLINGOT	VVILLE		HENDERSONVILLE, NC 2	28791		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 604	Continued From p	page 8	F	604			
	follow-up telephor PM, the MD stated #1 on 01/27/25 sh top of the right ha palm of the right h with no black esch he cleansed and provided in the cleansed and provided in the stated Resident # her fingers, good assesses the specapillaries) and not that occurs when reduced or blocked pulse. The MD st Resident #1 again reformation or skirt very good pulse a stated it was going injuries were improbands placed on blocked (movement of block (extra fluid that dratte body that isn't causing the blisted difficult to determing the place of the rubber bands had hands and wrists; (referring to the rubber bands had hands and intervies During an intervies	w on 01/29/25 at 4:20 PM and the interview on 01/29/25 at 5:33 and when he assessed Resident the had fluid-filled blisters on the mand that appeared superficial that appeared of motion in capillary refill (clinical test that the dot blood flow through the carterial compromise (condition blood flow to an area of body is d) when he checked her wrist atted when he evaluated to on 01/28/25, she had no blister in infection and she still had a not was moving her fingers. He go to take some time but her oving. He explained the rubber Resident #1's wrist did not ow as circulation was there but did decrease the venous flow and from the hand back to the ed up into the lymphatic flow that and tissues in the reabsorbed into the capillaries) are. The MD expressed it was the how long the socks and the been in place on Resident #1's however, without the binding libber bands) around Resident would have been no blisters.					
		Enforcement Officer revealed in forcement he also had an					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						,	С	
		345312	B. WING			02/	05/2025	
	ROVIDER OR SUPPLIER ENS AT HENDERSONV	/ILLE	•	1870 PI	T ADDRESS, CITY, STATE, ZIP CODE ISGAH DRIVE ERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 604	Medical Examiner at Law Enforcement Control Resident #1's handle and took photos of Enforcement Office Resident #1's handle was wrapped in a gwas almost deglove involves the skin and from the muscle and underneath) and the both the right and le Resident #1 had a not the right hand that he (cubic centimeters) he observed Resident wrist were red and a fingers which he feld (bacterial infection colong strands of skin were no blisters or shand but she did has her wrist. The Law was informed by the been placed around in place on her hand Officer stated he was investigation. Photographs taken wrists received via control officer were review photographs taken hand was covered in the side of the placed in the place	ackground that included and forensic pathology. The officer stated he observed so on 01/27/25 and 01/28/25 the injuries. The Law r stated when he observed so on 01/27/25, her right hand auze dressing. Her right hand ad (type of traumatic injury that ad soft tissue being torn away	F	604				

AND DIAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345312	B. WING _			l	05/2025
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE		STREET ADDRESS, CITY, STATE, ZIP C 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	ODE	, <u>v</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 604	inside the gauze dresvisualize a raised fluid base of the middle and the top of the hand. It moved to visualize the a blister and indentation wrist where the rubber remaining pictures tall the skin on Resident the wrist to the fingers on the top and palm. minimal redness with on the wrist. During a follow-up into PM, the investigating stated he spoke with photographs she took and rubber bands on wrists. He stated the Resident #1's wrists he tightly around her wrist. Photographs of Resident were taken by Nareceived via email confrom the investigating were reviewed. Theretotal. In the first photograph and show approximately 1/8 of a around the wrist twice	essing and appeared and ring fingers were bent sing and you could partially diffilled blister starting at the ad ring fingers leading down When the dressing was e wrist, the skin was red with from mark on the inside of the er bands had been. The ken on 01/28/25, revealed #1's right hand was red from and there was peeling skin. Her left hand and palm had no blisters and a red mark erview on 01/29/25 at 4:09 Law Enforcement Officer NA #1. NA #1 sent him are on 01/27/25 of the socks Resident #1's hands and pictures clearly showed and two rubber bands bound ests.	F	604			
		esting on the right hand and re not visible but you could					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	, , ,	(X3) DATE SURVEY COMPLETED	
		345312	B. WING _			C 2/05/2025	
	ROVIDER OR SUPPLIER	IVILLE		STREET ADDRESS, CITY, STATE, ZIF 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	CODE	2/03/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 604	sock. In the secon rubber bands had hand and her palm were red ligature in inside of her wrist. and fingers were wappearance. Thei blister from the ed her fingers that co. The sock was still visualize a rubber inch in width, bour the third photograp Resident #1's righ and tilted slightly. bruised area on the ligature mark. The fingers were brigh its normal size, resunderneath the outle were two raised fluthe hand and a fluther inger finger to A telephone interv #2 on 01/29/25 at she was employed verified she was a #1's care on Frida 7:00 AM to 3:00 P noticing socks or in hands or wrists. A telephone interv on 01/29/25 at 12: was employed by she was assigned	e her hand appeared in the nd photograph, the sock and been removed from the right in was facing upward. There marks on the lower part of the The skin on her wrist, hand visibly swollen and bright red in re was a large, raised fluid-filled ge of the palm to the bend of vered the width of the palm. On her left hand and you could band, approximately 1/8 of an individe around her wrist. In poh, was a left sided view of thand that was facing upward. There was a purple colored, we outer wrist along the red e skin from the wrist to the tred and swollen 2 to 3 times sembling a lobster claw. Just there edge of the top of the hand uid-filled blisters at the base of id-filled blister at the bend of	F	504			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD			(c	
		345312	B. WING			02/	05/2025	
	ROVIDER OR SUPPLIER ENS AT HENDERSONVI	LLE	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 870 PISGAH DRIVE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 604	3:00 PM. NA #2 starecall noticing if Resbands on her hands did notice the socks when she started he 01/26/25. She explaneatly around Residthem on her hands there by the previous keep her from messiasked what she meaplaced on Resident socks were pulled do and covered her har appearing to be tight recall noticing any ru#1's wrists holding the would have seen the #1 expressed that it bands could have be and she just didn't not a telephone interview on 01/30/25 at 2:42 employed by a staffin was assigned to proferiday 01/24/25 to Shours of 4:30 PM (st 7:00 AM and again of the hours of 3:00 PM recalled on 1/24/25 side of 500 Hall (side and NA #4 was assigned to proferiday 01/24/25 side of 500 Hall (side and NA #4 was assigned she could but stated at one point the point of the stated at one point the source of the stated at one point the source of the source of the stated at one point the source of the sou	ring the hours of 7:00 AM to ted she could not honestly ident #1 had socks or rubber or wrists on 01/24/25 but she on Resident #1's hands r shifts on 01/25/25 and sined the socks were placed ent #1's hands and she left hinking they had been put is shift as an intervention to ing in her feces. When into by the socks being neatly #1's hands, she stated the own to the tips of the fingers and but did not recall them it. NA #2 stated she did not ubber bands around Resident he socks in place and felt she is mif they had been there. NA was possible the rubber een folded up in the socks	F	604				

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			A. BOILD	ING _		Ι,	c	
		345312	B. WING				05/2025	
NAME OF P	ROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
THE CDE	ENS AT HENDERSONV	U. I. E.		1	1870 PISGAH DRIVE			
THE GRE	ENS AT HENDERSONV	ILLE		H	HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 604	were removed and a #4 placed new sock hands. At that point assist Resident #1's the room. When NA had rubber bands in around the privacy of stated she did not so bands around Resident #1's wrists again later in the shift thought that was strasocks on Resident # "that's just what they that was facility protous #1 from messing in knew that the use of bands on Resident # restraint and she did because he was sor to know the resident honestly did not thin would harm Resider about it the remaind a busy night. NA #3 her shift on 01/26/25 same socks on both rubber bands around 01/24/25 by NA #4. The socks looked who 01/26/25 or how Resident #1's he because most of the	I had socks on her hands that after care was provided, NA is back on Resident #1's in, NA #3 stated she went to roommate while NA #4 left in a #4 returned, she noticed he his hands and he went curtain to Resident #1. NA #3 is en NA #4 place the rubber it is ent #1's wrists but knew that rubber bands were on when she checked on her if it. NA #3 explained she ange when NA #4 put the it is hands but he told her if it is hands but he told her if it is hands were considered a first hands were considered a first hands were considered a first question NA #4 further it of training her and seemed its well. NA #3 stated she is the socks or rubber bands in #1 and didn't think much it is ercalled when she started it is recalled when she started in NA #3 could not recall how it is she started her shift on sident #1's hands and wrists bocks in place. NA #3 wasn't paying attention to lands presented on 01/26/25 is shift Resident #1 was it is shown in the recall hands were under	F	604				

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
345312	B. WING _			C 02/05/2025	
E		STREET ADDRESS, CITY, STATE, ZIP COD 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	E	32.33.2020	
MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BI	DATE	
ppeared larger than normal	F 6	04			
ber bands were placed on y NA #4 01/24/25 and o worked with Resident #1 nave seen the socks and					
M. NA #4 revealed he was agency and verified he 4/25 during the hours of on Resident #1's hall with NA #3 was assigned to idents on the left side of ent #1 resided and he was are to the residents on the NA #4 stated it was between 7:00 PM and to assist NA #3 with #1 after she had an NA #4 recalled when he esident #1's room he ating her feces and she body, mouth and inside of each he did not notice socks or rubber bands on the he used facility wipes to re and nails and he did not er bands on her hands A #4 stated after cleaning the assisted NA #3 with ed bath, changed the bed the room. He stated he ident #1's room the NA #4 stated he knew					
	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 14 ppeared larger than normal tated she knew for a fact ber bands were placed on y NA #4 01/24/25 and to worked with Resident #1 have seen the socks and all dropped the ball, herself was conducted with NA #4 M. NA #4 revealed he was agency and verified he 4/25 during the hours of on Resident #1's hall with NA #3 was assigned to idents on the left side of ent #1 resided and he was are to the residents on the NA #4 stated it was between 7:00 PM and t to assist NA #3 with #1 after she had an NA #4 recalled when he tesident #1's room he tesident #1's room he tating her feces and she body, mouth and inside of ted he did not notice socks or rubber bands on then he used facility wipes to re and nails and he did not ter bands on her hands A #4 stated after cleaning the assisted NA #3 with ed bath, changed the bed the room. He stated he ident #1's room the NA #4 stated he knew at Resident #1 would eat	IDENTIFICATION NUMBER: 345312 B. WING	A BUILDING 345312 B. WINS STREET ADDRESS, CITY, STATE, ZIP COD 1870 PISCAH DRIVE HENDERSONVILLE, NC 28791 ID PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) 14 ppeared larger than normal tated she knew for a fact ber bands were placed on y NA #4 01/24/25 and o worked with Resident #1 nave seen the socks and all dropped the ball, herself was conducted with NA #4 M. NA #4 revealed he was a gency and verified he 4/25 during the hours of on Resident #1's hall with NA #3 was assigned to idents on the left side of mit #1 resided and he was are to the residents on the NA #4 stated it was between 7:00 PM and t to assist NA #3 with #1 after she had an NA #4 recalled when he esident #1's room he aiting her feces and she body, mouth and inside of ied he did not notice socks or rubber bands on ien he used facility wipes to rs and nails and he did not are bands on her hands A #4 stated after cleaning he assisted NA #3 with ed bath, changed the bed the room. He stated he ident #1's room the NA #4 stated he knew at Resident #1 would eat	A BUILDING 345312 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791 TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 14 14 ppeared larger than normal lated she knew for a fact beer bands were placed on y NA #4 of 10/24/25 and o worked with Resident #1 have seen the socks and all dropped the ball, herself was conducted with NA #4 M. NA #4 revealed he was a gency and verified he 4/25 during the hours of on Resident #1's hall with NA #3 was assigned to idents on the left side of int #1 resided and he was re to the residents on the NA #4 stated it was between 7:00 PM and to assist NA #3 with #1 after she had an NA #4 recalled when he esident #1's room he aiding her feces and she body, mouth and inside of each he did not notice socks or rubber bands on eight he used facility wipes to ris and nails and he did not er bands on her hands A #4 stated after cleaning he assisted NA #3 with ed bath, changed the bed the room. He stated he ident #1's room the NA #4 stated he knew it Resident #1 would eat	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345312	B. WING _			02/0) 05/2025	
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE		STREET ADDRESS, CITY, STATE, ZIP 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		, , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 604	noticed her with sock asked staff about it the placed on her hands her feces and/or eating was asked who had to could not recall the national agency staff. NA #4 assigned residents the just cleaned them shower or bed bath, a rubber bands on their did not observe or plabands on Resident #7 he assisted NA #3 on who did. During a follow-up tel 02/05/25 at 3:01 PM, Enforcement Officer's message from NA #3 prior to the Law Enforwith NA #3 on 01/30/2 text message reveale that everyone though bands and socks on I would not take the fall did. A telephone interview #3 on 01/30/25 at 3:0 she was employed by was assigned to prov Saturday 01/25/25 at the hours of 7:00 AM stated on 01/25/25, Rof the day covered wirecall noticing Reside	mately a year ago, he had so on her hands and when he ey told him the socks were to keep her from messing in ag her feces. When NA #4 old him that information, he ames and stated they were explained anytime he had an at would dig in their briefs, up, usually gave them a and never put socks or hands. NA #4 restated he ace any socks and rubber 1's hands and wrists when 01/24/25 and was not sure	F	604				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CON	STRUCTION	(X3) DATE COMP	SURVEY
		345312	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	343312	5: 11:10	STREE	T ADDRESS, CITY, STATE, ZIP CODE	02/	05/2025
WANTE OF T	NOVIDEN ON GOIT EIEN				ISGAH DRIVE		
THE GRE	ENS AT HENDERSONV	/ILLE			ERSONVILLE, NC 28791		
	OU IN MA A FOV	OTATEMENT OF DEFICIENCIES		TILITE	<u>`</u>		0.00
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 604	Continued From pa	ge 16	F 6	604			
	Resident #1's hand	s but did not see any rubber					
		she did not remove the socks					
	from Resident #1's	hands to observe the skin and					
	explained the socks	s did not seem tight or swollen					
		edness to her arms that she					
		stated she didn't question why					
		ced on Resident #1's hands					
		that Resident #1 would play in					
	and eat her feces and no one had brought any concerns regarding the socks to her attention.						
	concerns regarding	the socks to her attention.					
	Δ telephone intervie	aw was conducted with NA #5					
	A telephone interview was conducted with NA #5 on 01/30/25 at 10:08 AM. NA #5 revealed she						
		ne facility and verified she					
		y 01/25/25 during the hours of					
		f on Resident #1's hall with NA					
	#2. She explained	NA #2 was assigned to					
	provide care to the	residents on the left side of					
	500 Hall where Res	sident #1 resided and she was					
		care to the residents on the					
	•	I. NA #5 recalled sometime					
		A #2 asked her to pull Resident					
	•	hen she did, she noticed					
		cks on each hand with one					
		d each wrist that was holding NA #5 stated she did not					
	•	isual about how her hands					
		ks on nor did she recall					
		of swelling or redness on the					
		expressed she did not					
		lent #1 had socks and rubber					
		s, did not remove them and					
		ocks were put on for a reason.					
	· ·	ew was conducted with NA #6					
		2 AM. NA #6 revealed she					
		staffing agency and verified					
		o provide care to Resident #1 25 to Sunday 01/26/25 during					
	UII Saluiday U I/25/.	zo to outluay o 1/20/20 dutitig		1			1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
			A. BOILD	iivo .		، ا	C	
		345312	B. WING				05/2025	
NAME OF P	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GRE	ENS AT HENDERSONVI	HE			1870 PISGAH DRIVE			
THE OILE	ENO AI TIENDERCONTI				HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 604	when she started he #1 had had socks or rubber band wrappe the socks in place. S bands were slid over or tight, and describe put a hair tie on their wanted to pull their h the nurses were the bands and she just a the socks and rubbe hands and wrists for didn't ask anyone ab assumed it was stan was told that Reside bottom and play with revealed she also we Monday 01/27/25 du 7:00 AM and had go to check on Residen were rubber bands w #1's wrist "multiple" if place and even with could see that Resid NA #6 stated NA #1 off of Resident #1's w her hands that had le the bed linens. NA # informed Nurse #1 w Resident #1. NA #6 or ask why Resident bands on her hands was not sure who pu hands.	It to 7:00 AM. NA #6 recalled or shift on 01/25/25, Resident in her hands with one (1) did around each wrist holding. She explained the rubber or the wrist, not wrapped twice edit like someone who would or wrist loosely in case they hair up. NA #6 stated usually only ones that had rubber assumed the nurses had put or bands on Resident #1's a particular reason and sout it. NA #6 stated she hadrad protocol because she int #1 liked to dig in her in/eat her fecal matter. NA #6 orked on Sunday 01/26/25 to be uring the hours of 11:00 PM to one into the room with NA #1 at #1. NA #6 recalled there wrapped around Resident times to hold the socks in the socks on her hands, you lent #1's hands were huge. Had to cut the rubber bands wrist and she had blisters on eaked through the socks onto #6 stated NA #1 immediately who came and assessed restated she did not question in #1 had socks and rubber and wrists on 01/25/25 and at them on Resident #1's	F	604				
	01/29/25 at 1:12 PM	and 01/31/25 at 10:18 PM Nurse #4 who was employed						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
			D WING			С
		345312	B. WING _			02/05/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
THE COE	ENS AT HENDERSONV	W. E		1870 PISGAH DRIVE		
THE GREE	ENS AT HENDERSONV	ILLE		HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 604	Resident #1's care	on and was assigned to provide on Saturday 01/25/25 during	F6	504		
	the hours of 7:00 Pf During interviews or 01/30/25 at 9:40 AM (DON) revealed she #1 on 01/27/25 arouthat she (Nurse #1) of Resident #1's hartightly around her wand the right hand hrecalled when she a 1:35 AM, Nurse #1 care and bandaged the DON removed t #1's hand, both han the right hand had sof the hand and one palm of the right hard the assessment, shindentation from the #1's wrists due to all did not display any sidiscomfort or pain. the Administrator to then started an inverse Resident #1 was even he started Resident prophylactically (tree protect against inferwound treatment two the MD stating base #1's injuries, the rubwirsts for less than in place any longer, cell death. She state Resident #1's Respense.	M to 7:00 AM. In 01/29/25 at 3:42 PM and M, the Director of Nursing In received a call from Nurse and 1:15 AM informing her had observed socks on both ands with rubber bands placed rists, both hands were swollen had blisters. The DON arrived at the facility around had already provided wound Resident #1's hand. When the bandages from Resident dis were pink and swollen and the veral blisters on the top part the large blister covering the had. The DON stated during the did not notice any the rubber bands on Resident If the swelling and Resident #1 signs or symptoms of The DON stated she called inform him of the incident and stigation. She stated aluated by the MD 01/27/25,				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345312	B. WING _			C 2/05/2025
	ROVIDER OR SUPPLIER	LE		STREET ADDRESS, CITY, STATE, ZIP COL 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		2/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 604	being put on Resider played with her feces used. She explained type of intervention would use as it was a DON verified socks psecured with rubber appropriate interventiand facility hired and during orientation that something the facility. During an interview of Administrator recalled AM on 01/27/25 and from the DON. He cainformed him of the in #1. When asked what he stated at that poin aftermath, basically tinjuries. The Administrator at the facility injuries. The Administrator at the facility injuries. The Administrator stated investigation, they initially blistered. Resident #1 red and swollen with Administrator stated investigation, they initial bands were placed of Sunday 01/26/25 dur 11:00 PM); however, details about when the actually placed on he been trained there was and neglect that included investigation and investigation and investigation and investigation and reglect that included indicated they we conducting an investigation and investigation and investigation and reglect that included indicated they we conducting an investigation and investigat	g aware that socks were at #1's hands because she and was ok with them being to Resident #1's RP that was not something the facility considered a restraint. The placed on the hands and coands was never an ion to use on any resident agency staff were informed at restraints were not a used. In 01/30/25 at 4:44 PM, the did he woke up around 5:30 noticed he had missed a call called the DON and she incident involving Resident at he was told by the DON, at she was describing the he extent of Resident #1's strator stated when he and observed Resident #1's a good deal of swelling in the with thand was red and it's left hand was a little less	F 6	04		

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345312	B. WING _		,	C)2/05/2025	
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		2/05/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 604	Continued From page		F 6	04			
	in place on Resident	nd rubber bands had been #1's hands.					
		ON and Regional Director of fied of Immediate Jeopardy PM.					
		the following Credible ate Jeopardy removal:					
	affected by the deficit On 1/27/2025, Reside sock on each hand, around each wrist to The facility failed to constraint policies and	se residents who have been ent practice: ent #1 was observed with a A binding had been placed hold the socks in place. comply with its abuse and did not protect a resident impairment from abuse					
	and sock from one har removed the sock an other hand for skin as included redness and hands, blisters to top singular blister measu	rse aide removed the band and, and the licensed nurse d band from resident #1's sessment. The injuries d edema to the bilateral of the right hand, and a uring, 17 centimeters x 20 meters to the palm of the					
	licensed nurse for an edema, and blistering edema and redness t assessment was com Nursing (DON) using no abnormal respirati	g to the right hand and to the left hand. Pain					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345312	B. WING _			C 02/05/2025	
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		02,00,2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 604	receives 0.25 milliliter solution 100 milligram day by mouth for pair cleansed with wound xeroform dressing an with kerlix. On 1/27/2025, DON r continue pain assess healed. On 1/27/2025, the ph phone of the incident (DON) with new treat On 01/27/2025, the D that resident #1 shou nurse) two times daily for psychosocial harm completed by observinormal routine, with resident with resident with resident psychosocial harm completed by observinormal routine, with resident with resident with resident psychosocial harm completed by observinormal routine, with resident psychosocial harm completed psychosocial har	ry to continue). Resident rs of morphine sulphate, oral n/5 milliliters two times per n. Bilateral hands were cleanser, patted dry, applied d loosely wrapped hands notified licensed nurses to ments until the wound is ysician was notified via by the Director of Nursing ment orders received. ON notified license nurses ld be assessed (by licensed of for 72 hours or as indicated of the the transport of the transp	F6	504			
	staff members who are socks and/or rubber it #1's hands and failing pending investigation On 01/27/2025, 1:1 e verbally by DON to st of socks on resident # policy, restraint policy behaviors to charge respectively.	ducation was provided aff who reported knowledge 41's hands regarding abuse of and reporting of unusual nurse.					
	On 01/27/2025, staff	members caring for resident					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345312	B. WING				05/2025
	ROVIDER OR SUPPLIER	l		s 1	STREET ADDRESS, CITY, STATE, ZIP CODE 870 PISGAH DRIVE HENDERSONVILLE, NC 28791	<u> 02/</u>	05/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	updates that reflect nobehaviors, and new in behaviors, and new in On 01/27/2025, Reside physician who provide treatment orders. On 01/27/2025, Provided additional dose of more of the order of the or	ediately by DON of care plan ew skin alterations, unusual interventions. Ident was assessed by ed wound care and updated der gave a one-time imphine prior to wound care. Ident was seen by wound care. Ident was seen by wound care. Ident was seen by wound covided treatment dice was notified by licensed ion of concerns. Inotified State law lit Protective Services upon erns. Identified State law lit Protective Services upon erns. Indiately following erns, DON initiated an gation is ongoing by and Assistant Director of Unit Managers. Intinues to work with facility to other action of the use of so on resident #1's hands,	F	604			

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345312	B. WING _			C 02/05/2025		
	IDER OR SUPPLIER AT HENDERSONVI	LLE		STREET ADDRESS, CITY, STATE, ZIP COD 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	E	02/03/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
Reference of the best of the b	ose with cognitive chaviors have the perficient practice. In 01/27/2025, all of DON for use of an Interest of the perfect of the performance of t	anot speak for themselves or impairments or those with potential to be affected by the other residents were assessed by restrictive device/restraint hats identified as having a pard copy of the assessment cility. Completed an audit of all so of 10 or greater. These viewed to determine if they ther incidents of using strict movement. There were and licensed nurses dit for all residents with a determine if they had any would indicate interventions into the movement. There were ard copies of the within the facility. and Administrator completed aff working over the last 5 thembers were interviewed to be aware of any other erventions that restrict there no new findings. The potential to be affected by the assessment of the potential to be put into place or systemic sure that the deficient	F 6	504				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345312	B. WING _			C 02/05/2025		
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE		STREET ADDRESS, CITY, STATE, ZIP O 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	ODE	T SEISSIZUZU		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BI THE APPROPRIA	DATE		
F 604	abuse. Education als have the right to be frunnecessary or excess including applying so hinder manifestations safety. Newly hired ceducated prior to accoraing for residents. Care without completing ADON will be responsibilities on 1/2 On 01/27/2025, DON staff in person and/or notification and approunsafe or other unusured or contracted staff will accepting an assignmental responsibilities on 1/2 will be responsible to including new hires a Administrator notified responsibilities on 1/2 How will the facility material to the deformation of the consure that the deformation of the consultation o	nce" for any type of resident to included that all residents see from harm, including asive physical restraint, cks and bindings to hands to of behaviors or for resident or contracted staff will be septing an assignment and No staff will provide resident ang education. DON and sible to track education for or hires and contract staff. DON and ADON of these 27/2025. Or designee educated all aby telephone to proper opriate intervention for all behaviors. Newly hired all be educated prior to ment and caring for all provide resident care ducation. DON and ADON track education for all staff and contract staff. DON and ADON of these 27/2025. Conitor its corrective actions are and hoc QAPI meeting a was completed and the root as the need for additional are use of restraints related to comes and resident abuse, to report unusual behavior. de to complete the following	Fé	604				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345312	B. WING			C 2/05/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	<u> </u>	2/05/2025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 604	Continued From pa	ge 25	F 60)4			
	residents per week assessments to ens of using intervention DON/designee will i weekly (on alternatii identify any concern improper behavior nabuse.	sure that there is no indication as that restrict movement. Interview 5 staff members and shifts) for 8 weeks to as for use of restraints, ananagement techniques, or or will review findings of audits					
	audits to QAPI for 2 needed to maintain IJ removal date is 1. The facility alleges of	/28/25. compliance with this plan of					
	for Immediate Jeopa on 01/31/25. Staff received inservice e of restraints policy v physical restraints. instructed that sock a resident's hands s intervention, was co report any concerns immediately. Revie sheets revealed star completed on 01/27 conducted on all co with no concerns ide residents were inter- concerns with restra	acility's corrective action plan ardy removal was completed interviews revealed they had education on the facility's use which included the definition of Staff verbalized they were and rubber bands placed on should never be used as an ensidered a restraint and to to the Administrator w of the attendance sign-in ff inservice education was 1/25. Skin assessments were gnitively impaired residents entified. Alert and oriented viewed who all reported no esidents with no other					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345312	B. WING			02/	05/2025
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE		18	TREET ADDRESS, CITY, STATE, ZIP CODE 870 PISGAH DRIVE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 604 F 607 SS=J	reported observing the bands on Resident #/inform anyone were simitiated on 01/27/25 to reviewed and comple facility's credible allegated noted as identified. To removal date of 01/28 Develop/Implement A CFR(s): 483.12(b)(1)-	All facility staff were 25 and the employees who e socks and/or rubber I but did not remove them or suspended. Monitoring tools through 01/31/25 were ted as outlined in the gation with no concerns The Immediate Jeopardy 8/25 was validated. buse/Neglect Policies -(5)(ii)(iii)		604			
	§483.12(b)(1) Prohibineglect, and exploitate misappropriation of results in sappropriation of results in sappropriation in sappropriation in sappropriation of results	t and prevent abuse, ion of residents and esident property, sh policies and procedures the allegations, and training as required at sh coordination with the ed under §483.75.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION		LETED
		345312	B. WING _				05/2025
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	,	00:2020
THE CDE	ENS AT HENDERSONVIL	IE		18	870 PISGAH DRIVE		
THE GREE	ENS AT HENDERSONVIL	.LE		HI	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 607	Continued From page	2 7	F 6	607			
	retaliation, as defined (2) of the Act. This REQUIREMENT by: Based on record revireview and staff interview and staff interview and staff interview and staff failed to report the use of a phwith no medical sympassessment for the nest staff reported observing Resident #1's hands bands wrapped arour without immediately radministrator. On 01 12:00 AM, Resident #1's covering each hand the rubber bands wrappe effectively forming too in emergency situation limb or extremity to stand the rubber bands remove the socks from Resident #1's right had (abnormally swollen of fluid in the bodies tiss appearance. There we top of the hand, a larger than and the rubber bands.	eed for a physical restraint. Ing socks placed on held in place by rubber and each wrist on 01/24/25 eporting to the /27/25 at approximately f1 was observed with socks hat were secured with d around each wrist, urniquets (device often used has to apply pressure to a hop blood flow) on her wrists, I manner. Her hands hormal through the socks had to be cut in order to m Resident #1's hands.			Past noncompliance: no plan of correction required.		
	ligature (visible inden around the right wrist evaluated by the Wou noted the blister on the	tation left on the skin) mark					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION		LETED
		345312	B. WING _			C 02/05/2025	
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE	,	1	STREET ADDRESS, CITY, STATE, ZIP CODE 870 PISGAH DRIVE HENDERSONVILLE, NC 28791	<u>, </u>	00:2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	F 607 Continued From page 28		F	607			
	applied daily. This wa	red wound treatment to be as for 1 of 3 residents nd restraints (Resident #1).					
	Findings included:						
	Protocol dated 06/13/statement that read in the right to be free from isappropriation, expunishment, physical imposed for purposes convenience and not resident's medical system of unknown and thoroughly invest management." The primplementation section staff member or person who witnessed or belivictim of mistreatment other criminal offense	in part, "Our residents have om abuse, neglect, ploitation, corporal or chemical restraints is of discipline or required to treat the imptoms, and involuntary is of resident abuse, neglect in source shall be promptly tigated by facility policy interpretation and on revealed in part, that any on affiliated with this facility ieved a resident had been a t, abuse, neglect, or any is shall immediately report the se to the Administrator or					
	disease, dementia an	nitted to the facility on ses that included Alzheimer's and multiple sclerosis (a affects the nervous system).					
	Aide (NA) #2 on 01/2 revealed she was em and verified she was Resident #1's care or	n 01/24/25, 01/25/25 and ours of 7:00 AM to 3:00 PM.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345312	B. WING _				05/2025
	ROVIDER OR SUPPLIER ENS AT HENDERSON	VILLE	•	STREET ADDRESS, CITY, STATE, ZIP C 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	:ODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 607	on her hands or widid notice the sock Resident #1's hand on 01/25/25 and 0' the socks on Residhad been put there intervention to kee feces. NA #2 verification Resident #1 had so report it to anyone, the socks should in hands she would hands she wolld hands and sasigned to proper any concern DON or Administration 01/30/25 at 2:42 employed by a star was assigned to proper on 01/26/25 during PM. NA #3 recalled an incontinence expher with cleaning under with cleanin	i #1 had socks or rubber bands ists on 01/24/25; however, she is but no rubber bands on its when she started her shifts 1/26/25. She explained she left lent #1's hands thinking they by the previous shift as an pher from messing in her ed she did not ask anyone why ocks on her hands nor did she She stated if she had known ot have been on Resident #1's ave told someone. NA #2 received inservice education is and neglect policy and instructed to immediately is to the Nurse Supervisor,	F6	607			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \ \		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 BOILE			,	
		345312	B. WING				05/2025
NAME OF P	ROVIDER OR SUPPLIER		-	ST	REET ADDRESS, CITY, STATE, ZIP CODE	, , , ,	
THE CDE	ENS AT HENDERSONVI	116		18	70 PISGAH DRIVE		
THE GRE	ENS AT HENDERSONVI	LLE		HE	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	wrists when she che shift. NA #3 explains socks on Resident # was strange but NA they do" and she just protocol to try and knessing in her feces received inservice the restraints and was in report any concerns she knew that the ust bands on Resident # restraint and she did question NA #4 furth training her and see well. NA #3 recalled on 01/26/25, Reside socks on both her has bands around her with 01/24/25 by NA #4. The socks looked who 01/26/25 or how Resident #1 since the socks and rubber baball, herself included A telephone interview on 01/30/25 at 10:08 was employed by the worked on 01/25/25 to 3:00 PM on Resident, NA #2 asked	bands were on Resident #1's cked on her again later in the ed that when NA #4 put the ed that was facility seep Resident #1 from es. NA #3 confirmed she had aining on abuse and estructed to immediately to administration. She stated se of the socks and rubber ed the socks and rubber ed the socks and rubber enter because he was sort of enter b	F	607			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345312	B. WING		02/05/2025		
	ROVIDER OR SUPPLIER ENS AT HENDERSONVI	LE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	1 02/00/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 607	around each wrist the place. NA #5 stated unusual about how he socks on nor did she swelling or redness of expressed she did not had socks and rubbe report it to anyone. Some remove them and just put on for a reason. The received inservice each abuse and neglect poinstructed to immediate the Administrator. A telephone interview on 01/30/25 at 11:32 was employed by a sea she was assigned to on 01/25/25 to 01/26 PM to 7:00 AM. NA her shift on 01/25/25 on her hands with on around each wrist he she explained the ruthe wrist, not wrapped described it like some on their wrist loosely their hair up. NA #6	and with one rubber band at was holding the socks in she did not notice anything er hands looked with the recall noticing any signs of on the visible skin. NA #5 of question why Resident #1 or bands on her hands or She stated she did not set assumed the socks were NA #2 confirmed she had lucation on the facility's policy and restraints and was ately report any concerns to was conducted with NA #6 AM. NA #6 revealed she staffing agency and verified provide care to Resident #1 /25 during the hours of 3:00 #6 recalled when she started a Resident #1 had had socks to (1) rubber band wrapped liding the socks in place, bber bands were slid over	F 60	,			
	and rubber bands on wrists for a particular anyone about it. NA was standard protoco Resident #1 liked to with/eat her fecal ma	e nurses had put the socks Resident #1's hands and reason and didn't ask #6 stated she assumed it of because she was told that dig in her bottom and play tter but realizes she should She confirmed she had					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345312	B. WING _			C 02/05/2025
	ROVIDER OR SUPPLIER ENS AT HENDERSONVI	LLE		STREET ADDRESS, CITY, STATE, ZIP C 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· ·	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 607	abuse and neglect properties instructed to immediate the Administrator. Note anyone why Resider bands on her hands did she report it to are as a selection of the Atelephone interview #3 on 01/30/25 at 3:0 she was employed be was assigned to prove 01/25/25 and 01/26/2 AM to 7:00 PM. Nursaw socks on both on the seen any rubber be remove the socks frow observe the skin and seem tight or swoller to her arms that she she didn't question we resident #1's hands because she knew the and eat her feces and concerns regarding the Nurse #3 confirmed seed and the state of the socks frow the socks from the socks frow the socks	ducation on the facility's policy and restraints and was ately report any concerns to A #6 restated she did not ask at #1 had socks and rubber and wrists on 01/25/25 nor anyone. We was conducted with Nurse A PM. Nurse #3 revealed by the facility and verified she wide care to Resident #1 on 25 during the hours of 7:00 se #3 stated on 01/26/25 she for Resident #1's hands but did ands. She stated she did not a mad there was no redness recalled. Nurse #3 stated on or report it to anyone that Resident #1 would play in the socks to her attention. She had received inservice allity's abuse and neglect and was instructed to	F	607	· · · · · · · · · · · · · · · · · · ·	
	Administrator. A telephone interview Aide (NA) #1 on 01/2 revealed she was en verified she was assi #1's care on Sunday 01/27/25 during the NAM. NA#1 recalled	v was conducted with Nurse 29/25 at 1:21 PM. NA #1 aployed by the facility and gned to provide Resident				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	X2) MULTIPLE CONSTRUCTION BUILDING		TE SURVEY MPLETED
		345312	B. WING			C 2/05/2025
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE		STREET ADDRESS, CITY, STATE, ZIP COD 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		210012020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 607	she went into Reside the covers she obser Resident #1's hands by rubber bands. NA rubber bands had be #1's wrists at least two tell Resident #1's hard the socks on because tightly against the sock than they should hav Resident #1's hands able to pull the socks to cut them in order to Resident #1's hands with the right hand arremoved, she immedight hand was very sand wrist was bright twere red marks around rubber bands had be Resident #1 also had the right hand and a palm of her right hand stated she immediate when Nurse #1 came Resident #1 she instrubber bands and so recalled Resident #1' but less red in appearshe recalled and ther Resident #1's left writh had been. NA #1 was and rubber bands on recalled staff mentior #1 messed with her finever witnessed Resident. NA #1 states	1 around 12:00 AM. When nt #1's room and pulled back ved socks on both of that were being held in place a #1 stated she thought the en wrapped around Resident vice. She stated she could hads were swollen even with the her hands were pressed cks and looked much bigger to been. She explained were so large, she was not or rubber bands off and had	F 60	07		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345312	B. WING		02/05/2025		
	ROVIDER OR SUPPLIER ENS AT HENDERSONVI	LE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	1 02/00/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION		
F 607	Continued From page 34		F 60	7			
	never have placed so	cleaned her up and would ocks and/or rubber bands on e behavior because it would raint.					
	#1 on 01/29/25 at 1:4 she was employed b was assigned to provide Sunday 01/26/25 to I hours of 11:00 PM to around 12:30 AM, Not her know that Reside on her hands, rubber and her hands were she immediately wer #1 had already remo bands off Resident # stated she cut the so Resident #1's right had red and her left I blistered. Nurse #1 on-call provider and phone call from the contraction.	was conducted with Nurse 18 PM. Nurse #1 revealed by the facility and verified she wide Resident #1's care on Monday 01/27/25 during the 7:00 AM. Nurse #1 recalled urse Aide (NA) #1 came to let ent #1 was found with socks bands around her wrists swollen. Nurse #1 stated at to assess Resident #1, NA wed the sock and rubber 1's right hand and Nurse #1 ck and rubber bands off and. Nurse #1 recalled and was swollen, blistered and was swollen but not notified the DON, called the while waiting for a return an-call provider, she went					
	right hand. Nurse #1 Resident #1's medica any physician orders her hands and there care plan either. Nur would play in her fec could only assume th placed the socks and however, that was no typically used. Nurse mentioned anything to	treatment to Resident #1's stated she looked through al records and did not see for socks to be placed on was no intervention in her rese #1 explained Resident #1 es on occasion and she hat was why someone had I rubber bands on her hands; of an intervention the facility e #1 stated no one had no her about the socks and ed on Resident #1's hands of her attention by NA #1.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345312	B. WING			C 02/05/2025	
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 870 PISGAH DRIVE HENDERSONVILLE, NC 28791	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
F 607	Continued From page During interviews on 01/30/25 at 9:40 AM, (DON) revealed she is #1 on 01/27/25 around that she (Nurse #1) h of Resident #1's hand tightly around her write and the right hand has she went to the facilite inform him of the incidinvestigation. The DO the hands and secure considered a restrain intervention to use or explained facility hire informed during orien not something the faci immediately report to Administration anytim in use. During an interview of Administrator recalled	e 35 01/29/25 at 3:42 PM and the Director of Nursing received a call from Nurse and 1:15 AM informing her ad observed socks on both dis with rubber bands placed ests, both hands were swollened blisters. The DON stated y, called the Administrator to dent and then started an DN stated socks placed on ed with rubber bands was at and never an appropriate in any resident. She did and agency staff were tation that restraints were cility used and they should her or another member of the restraints were observed. In 01/30/25 at 4:44 PM, the did he woke up around 5:30		607			
	from the DON. He cainformed him of the ir #1. When asked whathe stated at that poin aftermath, basically the injuries. The Administrated their investigation on 01/26/25 during set 11:00 PM); however, details about when the actually placed on he had been trained that	noticed he had missed a call alled the DON and she notident involving Resident at he was told by the DON, to she was describing the ne extent of Resident #1's strator stated when they attended to the property of the proper					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345312	B. WING _				05/2025
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE	1	STREET ADDRESS, CITY, STATE, ZIP CO 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	DE	, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 607	any suspicion of abus use of restraints and questions or concerns they had observed, the concerns to him or the Review of the initial at the facility to the Divis Regulation (DHSR) resident abuse and newith socks on her har hold the socks in place immediately removed were checked for sim other concerns identificated, and an invest was noted the facility incident on 01/27/25 awas submitted to DHS 01/27/25 at 2:43 AM anotified. The initial resigned by the Director Photographs taken of wrists received via en 01/28/25 from the inv Officer were reviewed photographs taken or hand was covered in the dressing was pull was outside of the dreswollen. The middle inside the gauze dresvisualize a raised fluic base of the middle and the top of the hand.	stated it was his vas to immediately report se which would include the explained if staff had s about something unusual ten they were to report their e DON. Illegation report submitted by sion of Health Service evealed an allegation type of oted Resident #1 was found ands and a "soft binding" to se. The socks were , all other facility residents illar interventions with no fied, staff education was estigation was underway. It was made aware of the at 1:15 AM, the initial report SR via fax transmission on and law enforcement was port was completed and or of Nursing (DON). Resident #1's hands and hail correspondence dated estigating Law Enforcement I. In the first three in 01/27/25, Resident #1's a gauze dressing and when ed back, the index finger	F6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345312	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER	343312	B. WING _	STR	EET ADDRESS, CITY, STATE, ZIP CODE	02/	05/2025
TVAINE OF T	NOVIDER OR OUT FIER				0 PISGAH DRIVE		
THE GRE	ENS AT HENDERSON\	/ILLE		HENDERSONVILLE, NC 28791			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	COMPLETION DATE
F 607	Continued From pa	ge 37	F 6	607			
		ation mark on the inside of the					
		ber bands had been. The					
		taken on 01/28/25, revealed					
		nt #1's right hand was red from					
		ers and there was peeling skin					
		n. Her left hand and palm had the no blisters and a red mark					
	on the wrist.	til no bilsters and a red mark					
	On the whst.						
	Photographs of Res	sident #1's hands and wrists					
	that were taken by NA #1 on 01/27/25 and received via email correspondence on 01/29/25						
	from the investigation	ng Law Enforcement Officer					
	were reviewed. The	ere were three photographs in					
		otograph, both of Resident					
		vered in grayish/tan gripper					
		nd was more prominent in the					
		owed two rubber bands,					
		of an inch in width, wrapped					
		ice and her hand above the					
		3 times its normal size in the					
		resting on the right hand and rere not visible but you could					
		her hand appeared in the					
		d photograph, the sock and					
		peen removed from the right					
		was facing upward. There					
	1	arks on the lower part of the					
		The skin on her wrist, hand					
	and fingers were vis	sibly swollen and bright red in					
		e was a large, raised fluid-filled					
	_	e of the palm to the bend of					
		ered the width of the palm.					
		on her left hand and you could					
		pand, approximately 1/8 of an					
		d twice around her wrist. In					
		h, was a left sided view of					
		hand that was facing upward					
	i and tilted slightly.	Γhere was a purple colored,					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345312	B. WING _			C 02/05/2025
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE		STREET ADDRESS, CITY, STATE, ZIP CO 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	DE	32:00:2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA	
F 607	ligature mark. The sliftingers were bright reits normal size, reserved underneath the outer were two raised fluidthe hand and a fluidthe hand and a fluidthe ringer finger to the The Administrator was Jeopardy on 01/29/25 provided the following Address how correcti accomplished for the affected by the deficit On 1/27/2025, resides sock on both hands a been placed around in place. This interveredness, and a 17 x 2 resident #1's right has on the left hand. The the abuse policy whe aware of the socks at failed to report this for administration. Because the facility did not procognitive impairment unnecessary restrain. On 01/27/2025, several admitted to knowledge bindings being on resto report, were suspended to report, were suspended to report, were suspended to report that the difference of Numerous attest that	cuter wrist along the red win from the wrist to the d and swollen 2 to 3 times abling a lobster claw. Just edge of the top of the hand filled blisters at the base of filled blister at the bend of e knuckle. Is notified of Immediate of at 6:00 PM. The facility grorrective action plan: We actions will be see residents who have been ent practice: In the facility and rubber bindings had each wrist to hold the socks and rubber bindings had each wrist to hold the socks and and redness and swelling afacility failed to comply with a facility failed to rubber bindings and facility failed to report, atect a resident with severe from abuse through the failure to report, atect a resident with severe from abuse through the failure who go of the socks and/or rubber bindent #1's hands and failing anded pending investigation.	F6	507		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION		LETED
		345312	B. WING				05/2025
	ROVIDER OR SUPPLIER	LE	•	18	TREET ADDRESS, CITY, STATE, ZIP CODE 870 PISGAH DRIVE ENDERSONVILLE, NC 28791	, <u>v-</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page On 01/27/2025, 1:1 e verbally by DON to st of socks and/or rubbe hands regarding abus the requirement to re abuse to the administ On 01/27/2025, imme identification of conce investigation. Investi Administrator, DON, and All perpetrators who a socks and/or bindings failed to report, and fa coverings and/or bind How will the facility id the potential to be aff practice: In an ad hoc Quality a Improvement (QAPI) abuse and reporting a dministrator to ensu In attendance at this	ducation was provided raff who reported knowledge or binding on resident #1's see policy, restraint policy and port suspected or actual trator or DON. dediately following erns, DON initiated gation is ongoing by and Assistant Director of Unit Managers. were aware of the use of so on resident #1's hands, ailed to remove the lings are being terminated. dentify other residents having ected by the same deficient		607			
	with all residents hav Mental Status (BIMS) that they had not exp not been reported. The	ON completed interviews ing a Brief Interview for of 10 or greater to ensure erienced any abuse that had here were no new findings. interviews reside in the					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345312	B. WING			C 02/05/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	IE	02/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	
F 607	or less to ensure thei abuse that had not be new findings. Hard or reside in the facility. On 1/27/2025, DON interviews with all states days. These staff medetermine if they wer incidents of using interviews of using interviews residents of using interviews residents of using interviews residents of using interviews residents and facility last 30 days to ensure examples of a failure required by facility at There were no new for the work of the work of the work of the practice will not occur. On 1/27/2025, the Dot staff education in per the facility abuse and include a "zero-toleral abuse or failure to reincident of abuse. Enable the including unnecessal restraint, including aphands to hinder man	re was no visual indication of the was no visual indication of	Fé	607		
	the requirement to re that could restrict mo	port any unusual devices vement, but to have open the Administrator, DON,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X:	(X3) DATE SURVEY COMPLETED	
		345312	B. WING _			C 02/05/2025	
	ROVIDER OR SUPPLIER ENS AT HENDERSONV	ILLE	,	STREET ADDRESS, CITY, STATE, ZIP C 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	ODE	32.00.2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 607	population, asking of any treatment or interpretation. Newly hire educated prior to accaring for residents. Care without complet ADON will be resported for all staff including The administrator not these responsibilities. On 01/27/2025, DOI staff in person and/onotification and apprenate or other unuscontracted staff will accepting an assign residents. No staff without completing will be responsible from the staff including new from administrator notification in the staff including new from the staff inc	nagers about the resident questions or inquiring about ervention that is new, ected as possible abuse or a ed or contracted staff will be ecepting an assignment and No staff will provide resident sting education. DON and ensible for tracking education new hires and contract staff. Dotified DON and ADON of so on 1/27/2025. Nor designee educated all or by telephone to proper repriate intervention for sual behaviors. Newly hired or be educated prior to ment and caring for will provide resident care education. DON and ADON or tracking education for all nires and contract staff. The d DON and ADON of these	F	507			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345312	B. WING		C 02/05/2025	
	ROVIDER OR SUPPLIER ENS AT HENDERSONV	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	02/03/2023	
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F 607	weekly (on alternati identify any concerr improper behavior rabuse to ensure that present. DON/designee will includes Sbars) 5 x any concerns for us behavior managemensure that reporting DON/designee will weekly for 8 weeks use of restraints, impresent and its to identify papresent audits to identify papresent audits to identify papresent audits to Quality the plan as needed IJ removal date is 1 The facility alleges action plan as of 1/2 A validation of the facility alleges on 01/31/25. Staff received inservice cabuse policy and us included the definition	interview 5 staff members ng shifts) for 8 weeks to as for use of restraints, management techniques, or at reporting has occurred if review the 24-hour report (that weekly for 8 weeks to identify se of restraints, improper ent techniques, or abuse to g has occurred if present. make a walking round 5 x to identify any concerns for aproper behavior management se to ensure that reporting has et a trator will review findings of techniques and will API for 2 months, adjusting to maintain compliance.	F 60	7		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345312	B. WING		1	C (05/2025
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		3E	(X5) COMPLETION DATE
F 609 SS=D	to the Administrator in attendance sign-in she education was compliassessments were compared residents will Alert and oriented residents all reported no conce was conducted on 01 no other restraints ide interviewed on 01/27/reported observing the bands on Resident #/inform anyone were simitiated on 01/27/25 reviewed and comple facility's credible allegated and comple facility's credible allegated to 01/28 Reporting of Alleged CFR(s): 483.12(b)(5): §483.12(c) In responsing pack, exploitation, must: §483.12(c)(1) Ensure involving abuse, neglimistreatment, includir source and misapproare reported immedia hours after the allegated that cause the allegated serious bodily injury, the events that cause abuse and do not reside administrator of the serious base in the administrator of the serious base in the serious and the se	t and to report any concerns mediately. Review of the leets revealed staff inservice leted on 01/27/25. Skin onducted on all cognitively the no concerns identified. Sidents were interviewed who may with restraints. An audit least of all residents with lentified. All facility staff were less and less and less who e socks and/or rubber of the suspended. Monitoring tools through 01/31/25 were leted as outlined in the legation with no concerns the Immediate Jeopardy 18/25 was validated. Violations (i)(A)(B)(c)(1)(4) See to allegations of abuse, or mistreatment, the facility		609		2/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED				
		345312	B. WING _		0	C 2/05/2025
	ROVIDER OR SUPPLIER	LE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
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F 609	for jurisdiction in long	e 44 ces where state law provides -term care facilities) in e law through established	F6	09		
	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective. This REQUIREMENT by: Based on record revireview and staff interview and staff interview and staff interview and extent of a residents reviewed for (Resident #1). Findings included: Review of the initial at the facility to the Divis Regulation (DHSR) resident #1 was four and a soft binding to Resident #1 was sleet have any mental anglimmediately removed were checked for sim other concerns identification.	administrator or his or her ative and to other officials in the law, including to the State of 5 working days of the eged violation is verified to action must be taken. It is not met as evidenced ew, photographic evidence views, the facility failed to to the State Agency that accurately reflected the aresident's injuries for 1 of 3 rabuse and restraints. Illegation report submitted by sion of Health Service evealed an allegation type of allegation details noted and with socks on her hands mold the socks in place. ping and did not appear to uish. The socks were all other facility residents illar interventions with no fied, staff education was		Criteria 1 The initial report was rectified upon submission of the investigation repsubmitted on 1/31/25, that detailed injury including wound measureme findings of the investigation, and the corrective actions taken by the factoriteria 2 On 2/12/25, an audit was complete the Administrator of all initial report completed from 1/12/25 to 2/12/25 determine trends or concerns related accurate reporting on the initial report (DHSR). All other reports reflected accurate information that was known that time of the report (prior to investigation). Criteria 3 On 2/12/25, the Administrator eduction that the Director of Nursing (DON) that	port d the ents, the he cillity. ed by ts to ted to port to tion d wn at	
	details of physical or	stigation was underway. The mental injury/harm revealed t this time. It was noted the are of the incident on		initial allegation reports must conta details of an incident as reported t regardless of whether they have h opportunity to visualize the injury of	o them, ad an	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	ı	(X3) DATE SURVEY COMPLETED
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		345312	B. WING _			02/05/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
THE CREI	ENS AT HENDERSONVI	E		1870 PISGAH DRIVE		
THE GREE	ENS AT HENDERSONVI	LLE		HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIAT	DATE
F 609	01/27/25 at 1:15 AM, the initial report was investigate the incident and that a clear					
	submitted to DHSR v 01/27/25 at 2:43 AM notified on 01/27/25	via fax transmission on and law enforcement was at 2:34 AM. The initial s completed and signed by		picture of what allegedly occonveyed to DHSR. Any uchanges to the initial allega corrected in the final invest Criteria 4 The Administrator will audit	curred is pdates or tion can be igation repor	
	that were taken by N and received via em. 01/29/25 from the in Officer were reviewe photographs in total. of Resident #1's han grayish/tan gripper s more prominent in the two rubber bands, as width, wrapped arou hand above the wrist normal size in the so the right hand and the visible but you could appeared in the sock	ident #1's hands and wrists lurse Aide #1 on 01/27/25 ail correspondence on vestigating Law Enforcement id. There were three In the first photograph, both ids were covered in ocks. The left hand was ne photograph and showed oproximately 1/8 of an inch in ind the wrist twice and her it appeared 2 to 3 times its ock. Her chin was resting on ine rubber bands were not visualize how large her hand ix. In the second photograph, bands had been removed		reports to DHSR monthly for ensure that all initial allegat contain details of an incider regardless of whether they visualized or investigated a picture of what allegedly occonveyed to DHSR. The Administrator will reviaudits in the monthly Qualit Process Improvement (QAI 2 months or until substantial is achieved. The audits will the discretion of the QAPI of The Administrator is resportant plan of correction. Date of compliance is 2/13/	or 2 months to cion reports on the astroported have been not that a clescurred is ew these ty Assurance PI) meeting for the all compliance I continue at committee.	d, ar or
	upward. There were lower part of the insi- her wrist, hand and f and bright red in app raised fluid-filled blis to the bend of her fin of the palm. The soc and you could visual approximately 1/8 of around her wrist. In left sided view of Rewas facing upward a a purple colored, bru	and her palm was facing a red ligature marks on the de of her wrist. The skin on fingers were visibly swollen bearance. There was a large, ter from the edge of the palm agers that covered the width ck was still on her left hand lize a rubber band, an inch in width, bound twice the third photograph, was a sident #1's right hand that und tilted slightly. There was uised area on the outer wrist e mark. The skin from the				

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		345312	B. WING _			02/	05/ 2025
	ROVIDER OR SUPPLIER ENS AT HENDERSONVIL	LE	1	STREET ADDRESS, CITY, STATE, ZIP CO 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	ODE	, <u> </u>	
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F 609	to 3 times its normal sclaw. Just underneat of the hand were two the base of the hand the bend of the ringer. During an interview on DON revealed she recondered on the content of the co	size, resembling a lobster in the outer edge of the top raised fluid-filled blisters at and a fluid-filled blister at finger to the knuckle. In 01/29/25 at 3:42 PM, the ceived a call from Nurse #1:15 AM informing her that observed socks on both of with rubber bands placed sts, both hands were swollened blisters. The DON arrived at the facility at M, Resident #1's hands resign after receiving #1 and she (Resident #1) ges removed until after the cer arrived at the facility and rent #1's hands together. The dath Administrator to inform dathen started an cluded submitting an initial ency. In 01/30/25 at 1:45 PM with of Operations and the DON was asked why atted there was no apparent and her only response was reted and submitted the initial observed Resident #1's tent of the actual injuries, reported by Nurse #1. The main focus when completing or get it submitted to the	F	609			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345312	B. WING _			C 02/05/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	I	02/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 609	During a joint interviewith the Administrator Regional Director of ODN was trying to ensubmitted on time an initially reported to he Regional Director of Of the injuries was do	w on 01/30/25 at 1:45 PM r and DON present, the Operations expressed the sure the initial report was d included the information by Nurse #1. The Operations stated the extent	F6	509		