STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING _____ B. WING _____	05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to accurately code the MDS (Minimum Data Set) in the areas of: anticoagulant medications for 1 of 5 residents (Resident #53) reviewed for unnecessary medications, wander/elopement alarm for 1 of 1 resident (Resident #18) reviewed for personal alarms, and therapeutic diet for 1 of 1 resident (Resident #31) reviewed for dialysis. Findings included: 1. Resident #53 was admitted to the facility on 04/14/17 with multiple diagnoses that included heart failure, diabetes and pulmonary embolism (blockage in the artery that carries blood from the heart to the lungs). A review was completed of Resident #53's most recent MDS dated 04/13/18 coded as an annual assessment. The MDS assessment indicated Resident #53 received an anticoagulant for 7 out of 7 days during the assessment period. A review of Resident #53's April 2018 physician orders and medication administration record revealed Resident #53 did not receive any anticoagulant medications during the MDS	F 641	The Laurels of Hendersonville wishes to have this written plan stand as its written allegation of compliance. Our alleged compliance is June 21, 2018. Preparation and/or execution of this written plan of correction does not constitute admission to, nor agreement with either the existence of or the scope and severity of any of the cited deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F641: Accuracy of Assessments Corrective Action: A modification Minimum Data Set (MDS) was completed for resident #53 related to not being on an anticoagulant during the look back period for MDS dated 4/13/2018. A modification MDS was completed for resident #18 related to use of wander/elopement alarm use during the look back period for MDS dated 2/21/2018. A modification MDS was completed for resident #31 for receiving a therapeutic diet during the look back period for MDS dated 4/1/2018. Processes leading to the deficiency cited include lack of review of the orders for therapeutic diets, anti coagulants and	6/21/18

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

Electronically Signed | 06/08/2018

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.

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F 641	Continued From page 1 assessment period. An interview was conducted on 05/23/18 at 2:16 PM with the MDS Nurse who was currently responsible for completing the MDS assessments. The MDS Nurse confirmed Resident #53 did not receive any anticoagulant medication during the assessment period and the MDS dated 04/13/18 was coded incorrectly for anticoagulant use. She added a modification would need to be submitted. An interview was conducted on 05/23/18 at 3:10 PM with the DON (Director of Nursing) who revealed it was his expectation for MDS assessments to be accurately coded. 2. Resident #18 was admitted to the facility on 07/13/17 with multiple diagnoses that included dementia with behavioral symptoms and agitation. A review of Resident #18's electronic medical record revealed a physician order dated 01/07/18 which read, check wander bracelet placement every shift and check wander bracelet function every night shift. A review was completed of Resident #18's most recent MDS dated 02/21/18 coded as a quarterly assessment. The MDS assessment indicated a wander/elopement alarm was not used during the MDS assessment period.	F 641	wander/elopement alarms that were in place during the look back period. Corrective Action for those having the potential to be affected: An audit of all current resident diet orders, residents on anticoagulants and residents with wander/elopement bracelets was completed by the corporate MDS consultant to ensure accurate MDS coding. Any alterations identified will be corrected/modified as appropriate. June 8, 2018 Systematic Changes: The MDS corporate nurse provided education to MDS staff on accuracy of coding MDS and review of current diet, anticoagulant and wander/elopement bracelet orders. June 8, 2018 Monitoring: The corporate MDS consultant will audit new MDS's weekly for one month then bimonthly for two months to ensure compliance with resident's diet orders, anticoagulant orders, and wander guard orders. Results of these audits will be reviewed monthly at the Quality Assurance Committee meeting for further recommendations. The corporate MDS consultant will implement the plan of correction and ensure any additional recommendations are carried out.	

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F 641	Continued From page 2	F 641		

An observation of Resident #18 on 05/21/18 at 2:08 PM revealed a wander bracelet alarm around her left ankle. Additional observations of Resident #18 on 05/23/18 at 11:50 AM and 05/23/18 at 11:01 AM revealed she had a wander bracelet alarm around her left ankle.

Resident #18 was unable to be interviewed due to cognition.

An interview was conducted on 05/23/18 at 2:16 PM with the MDS Nurse who was currently responsible for completing the MDS assessments. The MDS Nurse confirmed she had missed coding the wander bracelet alarm for Resident #18. She added a modification would need to be submitted for the MDS assessment dated 02/21/18.

An interview was conducted on 05/23/18 at 3:00 PM with Nurse #1 who revealed Resident #18 was checked each shift to ensure the wander bracelet alarm was in place. Nurse #1 added the wander bracelet alarm was implemented for Resident #18 shortly after her admission to the facility and worn at all times for exit seeking behaviors and safety.

An interview was conducted on 05/23/18 at 3:10 PM with the DON who revealed it was his expectation for MDS assessments to be accurately coded.

3. Resident #31 was admitted to the facility on

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F 641	Continued From page 3	F 641		

10/31/18 with diagnoses including diabetes, asthma, and end stage renal disease.

A quarterly Minimum Data Set (MDS) dated 4/1/8 revealed Resident #31 was not coded as receiving a therapeutic diet.

A review of the Physician orders for Resident #31 revealed an order for consistent carbohydrate diet dated 1/5/18.

The Care Area Assessment Summary (CAA summary) for nutritional status dated 1/10/18 revealed Resident #31 was at risk for weight loss related to end stage renal disease and diabetes and was on a consistent carbohydrate diet.

The MDS Coordinator was interviewed 5/24/18 at 10:52 am regarding the accuracy of Resident #31's quarterly MDS. The MDS did not reflect Resident #31 was receiving a therapeutic diet. The MDS Coordinator stated the MDS should have been coded to reflect Resident #31 was receiving a therapeutic diet and was incorrectly coded. The MDS Coordinator stated the quarterly MDS would require a correction to reflect Resident #31 was receiving a therapeutic diet.

On 5/24/18 at 11:12 am an interview was conducted with the Director of Nursing (DON). The DON stated it was his expectation that the quarterly MDS would have been coded accurately to reflect Resident #31 was receiving a therapeutic diet.

On 5/24/18 at 11:29 am an interview was conducted with the Administrator. The Administrator stated it was her expectation that

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F 641	Continued From page 4 the quarterly MDS would have been coded accurately to reflect Resident #31 was receiving a therapeutic diet.	F 641		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure and label unidentified loose pills in of 2 of 4 medication carts (400 hall and 100 hall).	F 761	F761 Label/Store Drugs and Biologicals Corrective Action: All medication carts were inspected for loose pills at the time of discovery of loose	6/21/18

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F 761	Continued From page 5 Findings included: 1. An observation on 5/22/18 at 1:08 pm of the 400 hall medication cart revealed one half of an unidentified pill was loose in the bottom drawer. An interview with the 400 hall nurse at the time of the observation revealed she was unable to identify the medication and did not know how or why the pill became loose in the cart. The nurse discarded the loose pill at that time. The nurse stated if she found loose pills in the medication cart she discarded them. 2. An observation on 5/22/18 at 1:51 pm of the 100 hall medication cart revealed 5 unidentified loose pills. An interview with the 100 hall nurse at the time of the observation revealed she was unable to identify the medications and did not know how or why the pills became loose in the cart. The nurse discarded the loose pills at that time. The nurse stated if she found loose pills in the medication cart she discarded them. An interview with the Director of Nursing (DON) on 5/22/18 at 1:55 pm revealed it was his expectation that medication carts be free of loose pills. The DON also stated that third shift nurses were responsible for cleaning out the medication carts nightly and he was unsure why there were loose pills in the medication carts. An interview with the Administrator on 5/24/18 at 11:35 am revealed it was her expectation that all medication carts be free of loose pills.	F 761	pills in the 100 and 400 hall cart and none were found. June 8, 2018. Processes that may have led to the cited deficiency include the nurses not checking for loose pills that are inadvertently dislodged from the pill packs at the end of the medication pass. Corrective Action for those having the potential to be affected: All medication carts have the potential to be affected. Systemic Changes: The ADON will provide education to licensed nurses on checking medication carts for loose pills that may have inadvertently become dislodged from packaging or dropped in medication cart drawers at the end of the medication pass. June 21, 2018 Monitoring: The Director of Nursing (DON) will audit medication carts weekly for one month then bimonthly for two months to ensure compliance with not having loose medication in medication cart drawers. Results of these audits will be reviewed monthly at the Quality Assurance Committee meeting for further recommendations. The DON will implement the plan of correction and ensure any additional recommendations are carried out.	