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 _____	C 03/05/2020

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 03/02/20 through 03/05/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #VCT711.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted 03/02/20 through 03/05/20. A total of 2 allegations were investigated and 1 was substantiated. Event ID #VCT711.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		4/1/20

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

Electronically Signed | 03/28/2020

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F 561	Continued From page 1 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to provide showers as scheduled for 2 of 3 residents reviewed for choices (Residents #64 and #62). The findings included: 1. Resident #64 was admitted on 07/06/17 following a cerebral infarct. Review of the quarterly Minimum Data Set (MDS) dated 02/21/20 indicated Resident #64 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing and toileting, and limited assistance with personal hygiene. Resident #64 was totally dependent on staff for bathing. Resident #64 did not reject care or exhibit any behaviors. The shower/bathing record for February 2020, Resident #64 was given showers on 02/06/20, 02/19/20, and 02/27/20, indicating Resident #64 went 12 days without a shower. On 02/10/20 and 02/13/20 it was documented that Resident #64 did not receive a shower and on 02/17/20 there was no documentation to indicate if a shower had or had not been provided. The grievance log revealed that on 02/19/20 Resident #64 had filed a grievance indicating he had not had a shower in 2-3 weeks. Resident #64	F 561	The Laurels of Hendersonville requests to have this submitted plan of correction stand as its written allegation plan of compliance. Our compliance date is 4/1/2020. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope of severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. F561 Self Determination The facility will continue to promote and facilitate resident self-determination through support of resident choice. Resident #62 and #64 shower schedules and preferences have been discussed individually and preferences documented within their electronic task records. All residents in the facility have the ability to be affected. No negative outcome was identified relating to this observation. All residents in the facility will have shower schedules and preferences updated within their electronic record before 4/1/2020. Additionally, residents involved in resident council meeting were educated on	

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F 561	Continued From page 2 was given a shower on 02/19/20 and the grievance was considered resolved. On 03/02/20 at 3:30 PM an interview was completed with Resident #64 who reported he did not always get showers as scheduled and recently he had gone 3 weeks without being offered a shower. An interview was completed with Nurse Aide (NA) #1 on 03/04/20 at 2:21 PM who had documented that Resident #64 did not get a shower on 02/10/20. The NA stated that Resident #64 did not get his shower on 02/10/20 and it was probably because they did not have enough staff on that day. NA #1 indicated that when staffing was short, showers were not always provided. An interview was completed with NA #2 on 03/04/20 at 2:25 PM, NA #2 had documented that Resident #64 was not given a shower on 02/13/20. The NA indicated that Resident #64 probably did not get his shower on that day because there was not enough staff to provide them. NA #2 stated that the shower team had likely been pulled to work a hall on that day. NA #2 reported that when the shower team was pulled to work a hall, she was sometimes able to provide showers, but not always. An interview was completed with NA #3 on 03/04/20 at 2:35 PM. NA #3 was scheduled to work Resident #64's hall on 02/17/20. NA #3 reported that she did not give any showers on that day. NA #3 further indicated that the NA who was usually scheduled to give showers (shower team) had to work a hall that day as there was not enough staff. NA #3 indicated that it was likely no one had been given showers on 02/17/20.	F 561	different avenues to report grievances with regard to showers, care related issues, or other general matters. The Assistant Director of Nursing has provided in-servicing on 3/13/2020 to staff providing resident care with the ability to document activities of daily living to ensure care is documented, specifically shower documentation/charting. A QA monitoring tool will be created for: documentation/charting audits performed weekly for 12 weeks. Audits of shower documentation will reflect care has been provided for each guest as requested. The Unit Manager will be responsible for completing these audits. The facility will audit for 12 weeks, results will be reported to DON with any variance addressed. The DON will report the weekly findings to the Administrator for review for the next 3 months. Audit results will be reviewed for the next 3 months by the Quality Assurance Committee to ensure compliance and/or to provide additional retraining if needed. Continued compliance will be monitored through random audits of shower documentation and through the facilities Quality Assurance Program.	

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F 561	Continued From page 3	F 561		

In an interview on 03/05/20 at 1:31 PM with the Assistant Director of Nursing (ADON) it was reported that the facility was aware that showers had not been provided as scheduled. The ADON reported she was looking into implementing a new system for showering to correct the issue. The ADON stated that showers had not been provided because there were not enough staff members. The ADON indicated it was her expectation that showers were provided as scheduled.

On 03/05/20 at 1:49 PM the Administrator was interviewed who stated that Resident #64 had come to her on 02/19/20 and reported he had not had a shower in a few weeks. She then filed a grievance for him and had staff give him a shower on that same day. The Administrator indicated that because staffing was an area the facility was having trouble with, showers had not been provided as scheduled. The Administrator reported the facility was working on a new staffing model to correct the issue and that it was her expectation that showers were provided as scheduled.

2. Resident #62 was admitted to the facility on 09/16/19 with multiple diagnoses that included diabetes, chronic kidney disease with heart failure, vascular dementia without behavioral disturbance, and anxiety disorder.

The quarterly Minimum Data Set (MDS) dated 02/07/20 assessed Resident #62 with intact cognition. The MDS indicated Resident #62 required limited to extensive staff assistance with all activities of daily living except for eating and displayed no rejection of care. It was further

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F 561	Continued From page 4	F 561		

noted bathing activity did not occur during the MDS assessment period.

The shower/bathing record for January 2020 revealed Resident #62 was scheduled to receive 2 showers per week on Tuesdays and Fridays. It was documented Resident received showers on 02/22/20 and 02/28/20; however, there was no documentation Resident #62 received bathing assistance on 02/04/20, 02/07/20, 02/11/20, 02/14/20, 02/18/20, or 2/25/20 indicating Resident #62 went 21 days without a shower.

During an interview on 03/02/20 at 9:21 AM Resident #62 shared she was supposed to receive 2 showers per week but usually only received one. Resident #62 added just last month, she went 2 weeks without a shower and when she mentioned it to staff, they stated they would try to give her one if they had time.

During an interview on 03/03/20 at 9:21 PM Nurse Aide (NA) #4 confirmed she was assigned to provide care to Resident #62 on 02/04/20, 02/11/20 and 02/14/20. NA #4 explained she was part of the shower team but had been pulled to work the hall as a NA on those days and was not able to provide her assigned residents with their scheduled shower, including Resident #62, due to the facility being short-staffed. NA #4 added when working short-staffed, their main focus was just to keep residents clean, dry and fed.

During an interview on 03/05/20 at 10:30 AM NA #5 confirmed she was assigned to provide care to Resident #62 on 02/18/20 and 02/25/20. NA #5 explained as a hall NA, she focused on the basic care needs of the residents assigned and the shower aide for the hall provided all scheduled

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F 561	Continued From page 5	F 561		

showers. NA #5 added whenever the shower aide was pulled to work the floor, showers did not get provided to the residents. NA #5 reported she had never provided Resident #62 with a shower.

During an interview on 03/05/20 at 2:11 PM, NA #6 shared she was part of the shower team and was assigned to the 200 Hall to provide resident showers on 02/07/20, 02/18/20, and 02/25/20. NA #6 stated staffing has been a challenge and most days, she was pulled from the shower team to work the floor as a NA. NA #6 shared when she was not pulled to work the floor, showers were provided as scheduled and she was supposed to document in the resident's electronic medical record when the shower was provided or refused. NA #6 reviewed Resident #62's electronic bathing documentation and confirmed there was nothing documented for the dates she was assigned to provide showers. NA #6 verbalized when she forgot to document, the Unit Manager would call her to ask if the shower was provided and usually documented for her but if nothing was documented then the shower was not provided. NA #6 indicated it was likely she was pulled from the shower team on 02/07/20, 02/18/20 and 02/25/20 to work the hall as a NA due to the facility not having enough staff and did not have the time to provide her assigned residents with their scheduled shower.

During a joint interview on 03/05/20 at 8:54 AM, the Assistant Director of Nursing (ADON) reported the facility was aware showers were not being provided to residents as scheduled due to staffing issues and was looking into implementing a new system for showering to correct the issue. The ADON verbalized it was her expectation that resident showers were provided as scheduled.

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F 561	Continued From page 6 During a joint interview on 03/05/20 at 8:54 AM, the Administrator stated the facility had faced staffing challenges and as a result, the shower aides were often pulled to the floor to work as a NA and showers were not provided to residents as scheduled. The Administrator explained they tried to make up the showers that were missed and were working on a new staffing model to correct the issue. The Administrator verbalized she was aware of resident complaints that showers were not being provided as scheduled and stated she would believe Resident #62 if she stated she did not receive a shower. The Administrator added it was her expectation that showers were provided as scheduled.	F 561		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		4/1/20

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F 582	Continued From page 7 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a CMS-10055 SNF ABN (Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice) prior to discharge from Medicare Part A skilled services to 2 of 3 residents reviewed for	F 582	The facility will provide each Medicaid/Medicare Coverage/Liability eligible resident, in writing, at the time of admission to the facility and when the resident becomes eligible or changes eligibility for items or services that are	

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F 582	Continued From page 8 beneficiary protection notification review (Residents #31 and #70). Findings included: 1. Resident #31 was admitted to the facility on 02/05/19. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #31's family member on 12/13/19 which indicated Medicare Part A coverage for skilled services would end on 12/16/19. Resident #31 remained in the facility after the NOMNC was issued with Medicare Part A benefits remaining. A review of the medical record revealed a CMS-10055 SNF ABN was not provided to Resident #31. During an interview on 03/03/20 at 3:50 PM, the Social Worker (SW) indicated she was responsible for issuing the NOMNC to the resident or their Responsible Party (RP) once notified the resident's Medicare Part A coverage for skilled services was ending. The SW added she was aware a SNF ABN was also required when the resident remained in the facility with Medicare Part A benefits remaining. The SW explained she and the previous Business Office Manager (BOM) had a system in place where the previous BOM issued the SNF ABN and she issued the NOMNC; however, the current BOM had only been at the facility for a few months and they had not yet had a chance to work out a process of who was responsible for providing the required SNF ABN notice. She confirmed the SNF ABN was not provided to Resident #31 and	F 582	include in the nursing facility services under Medicare and/or State plan and for which the resident may not be charged; and those items and services that the facility offers and for which the resident may be charged, and the amount of the charges for those services; and inform each eligible resident when changes are made to the items and services. Resident #31 no longer resides in the facility. Resident #70 currently resides in the facility without issue. Potential residents to be affected include: all residents in which Medicare Part A coverage for skilled services ends and the resident remains in the facility with Medicare Part A benefits remaining. No negative outcomes were identified relating to this observation. The facility Business Office Manager and Social Workers were in-serviced on 3/4/2020 by the Administrator on the policy with regard to issuing SNF ABN along with Medicare denials according to CMS guidelines. The Social Worker will be responsible for issuing ABN going forward. The Administrator will audit all residents who discharge Medicare Part A and remain in the facility weekly for the next 4 weeks, and then randomly for the next two months. Continued compliance will be monitored through random audits of Medicare A discharged patients and through the	

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F 582	Continued From page 9 stated Resident #31's Medicare Part A coverage ended around the time of the transition with the new BOM and the SNF ABN got overlooked. During an interview on 03/03/20 at 4:17 PM, the Administrator reported Resident #31's Medicare Part A coverage ended right around the time the new BOM started his employment with the facility. The Administrator stated she would have thought the SW would have provided the SNF ABN when the NOMNC was issued but realized they had no system in place that identified a responsible person for ensuring SNF ABN were provided. The Administrator stated she would expect for staff to issue the required notices to residents and/or their RP when Medicare Part A skilled services were ending. 2. Resident #70 was admitted to the facility on 09/08/19. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was provided to Resident #70's family member on 10/16/19. The notice indicated that Medicare Part A coverage for skilled services would end on 10/18/19. Resident #70 remained in the facility after the NOMNC was issued with Medicare Part A benefits remaining. A review of the medical record revealed a CMS-10055 SNF ABN was not provided to Resident #70. During an interview on 03/03/20 at 3:50 PM, the Social Worker (SW) indicated she was responsible for issuing the NOMNC to the resident or their Responsible Party (RP) once notified the resident's Medicare Part A coverage	F 582	facility's Quality Assurance Program. The Administrator will convey audit result to QA Committee and ompliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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F 582	Continued From page 10 for skilled services was ending. The SW added she was aware a SNF ABN was also required when the resident remained in the facility with Medicare Part A benefits remaining. The SW explained she and the previous Business Office Manager (BOM) had a system in place where the previous BOM issued the SNF ABN and she issued the NOMNC; however, the current BOM had only been at the facility for a few months and they had not yet had a chance to work out a process of who was responsible for providing the required SNF ABN notice. She confirmed the SNF ABN was not provided to Resident #70 and stated Resident #70's Medicare Part A coverage ended around the time of the transition with the new BOM and the SNF ABN got overlooked. During an interview on 03/03/20 at 4:17 PM, the Administrator reported Resident #31's Medicare Part A coverage ended right around the time the new BOM started his employment with the facility. The Administrator stated she would have thought the SW would have provided the SNF ABN when the NOMNC was issued but realized they had no system in place that identified a responsible person for ensuring SNF ABN were provided. The Administrator stated she would expect for staff to issue the required notices to residents and/or their RP when Medicare Part A skilled services were ending.	F 582		
F 641 SS=E	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:	F 641		4/1/20

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THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

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F 641	Continued From page 11 Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of medications, discharge status, hospice and prognosis for 4 of 10 sampled residents (Resident # 82, #44, #87, and #69). Findings included: 1. Resident #82 was admitted to the facility on 03/22/19 with multiple diagnoses that included type 2 diabetes mellitus (DM) with hyperglycemia. Review of medication administration record for the month of February 2020 indicated Resident #82 had received insulin injection daily for DM during the 7-day look back period. Review of Resident #82's electronic profile revealed type 2 DM with hyperglycemia was listed among other diagnoses. Review of the significant change in status assessment Minimum Data Set (MDS) dated 02/25/20 indicated Resident #82 had not been coded under Section N 0350 as receiving insulin during the 7-day look back period. During a phone interview on 03/02/20 at 11:39 AM, MDS Coordinator #1 stated the significant change MDS dated 02/25/20 was completed for Resident #82 due to skin concerns and weight loss. She acknowledged that Resident #82 was receiving insulin daily during the 7-day look back period and confirmed Section N 0350 was coded incorrectly. The MDS Coordinator explained it was an oversight and a modification would be submitted.	F 641	The facility will continue to complete assessments that accurately reflect the resident's status. Resident #82, #44,and #69 had MDS corrections completed at the time of discovery. Resident #87 is no longer in the facility. No negative outcome was identified related to this observation. All current residents in the facility have the potential to be affected. An audit of the MDS assessments completed within the last 3 months relating to medications, discharge status, an hospice and prognosis was conducted at the time of survey by the MDS Nurse. Any other resident found to be affected by this alleged deficient proactive had a correction mad to the MDS by the MDS Nurse. No negative observations were identified. The MDS Coordinator and Assistant were in-serviced by the Clinical Resource Specialist on 3/16/2020 completing assessments that accurately reflect the resident's disposition. A QA monitoring toll will be utilized by the DON to ensure ongoing compliance. The DON will randomly audit MDS assessments weekly for 4 weeks, and then randomly for 2 months to ensure that MDS assessments are being completed that accurately reflect the resident's disposition. Variances will be corrected at the time of audit and additional education provided when indicated.	

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 _____	C 03/05/2020

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	Continued From page 12 During an interview on 03/05/20 at 10:43 AM, the Assistant Director of Nursing (ADON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of recent staff turnover in MDS department. The DON stated it was her expectation for all MDS assessments to be coded accurately. During an interview on 03/05/20 at 1:25 PM, the Administrator stated the MDS department required two full time MDS Coordinators to handle the workload. However, due to staff turnover, MDS Coordinator #1 had been working alone in the past 6 months with a part-time MDS Coordinator working for only 6 hours per week. The Administrator attributed the incidents as an oversight due to carelessness. It was her expectation for all MDS assessment to be coded accurately to reflect the clinical needs or conditions of the Resident. 2. Resident #44 was admitted to the facility on 08/14/17 with multiple diagnoses that included anemia, heart failure, diabetes mellitus, anxiety, and depression. Review of medication administration record for the month of January 2020 indicated Resident #44 had received Effexor extended release (an antidepressant) every night at bed time for depression during the 7-day look back period. Review of Resident #44's electronic profile revealed depression was listed among other diagnoses. Review of the quarterly review assessment Minimum Data Set (MDS) dated 01/13/20 indicated Resident #44 had not been coded	F 641	Audit results will be reported to the Administrator for the next 3 months and concern will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits of MDS assessments and through the facility's Quality Assurance Program. The Administrator will convey results to QA Committee and compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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	345322	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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F 641	Continued From page 13	F 641		

under Section N 0410 as receiving antidepressant during the 7-day look back period.

During an interview on 03/03/20 at 1:03 PM, the MDS Coordinator #2 confirmed Section N 0410 was coded incorrectly and indicated that Resident #44 was receiving antidepressant daily in the 7-day look back period. She explained she was not the MDS Coordinator who completed this MDS as she had been working for less than 2 weeks. She would correct the error and a modification would be submitted.

During an interview on 03/05/20 at 10:43 AM, the Assistant Director of Nursing (ADON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of recent staff turnover in MDS department. The DON stated it was her expectation for all MDS assessments to be coded accurately.

During an interview on 03/05/20 at 1:25 PM, the Administrator stated the MDS department required two full time MDS Coordinators to handle the workload. However, due to staff turnover, MDS Coordinator #1 had been working alone in the past 6 months with a part-time MDS Coordinator working for only 6 hours per week. The Administrator attributed the incidents as an oversight due to carelessness. It was her expectation for all MDS assessment to be coded accurately to reflect the clinical needs or conditions of the Resident.

3. Resident #87 was admitted to the facility on 01/21/20 with multiple diagnoses that included acute bronchiolitis, anxiety, and chronic pain.

Review of progress notes dated 01/31/20

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 _____	C 03/05/2020

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

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F 641	Continued From page 14	F 641		

revealed Resident #87 was discharged home that day.

Review of physician's orders dated 01/30/20 indicated Resident #87 was discharged home with home health provided at home.

Review of post discharge plan of care dated 01/27/20 indicated Resident #87's discharge location would be independent living and discharge date would be on 01/30/20.

Review of the discharge Minimum Data Set (MDS) dated 01/30/20 indicated Resident #87 had been coded under Section A 2100 for discharge status as discharged to acute hospital.

During an interview on 03/03/20 at 2:03 PM, the Social Worker confirmed Resident #87 was discharge home on 01/30/20 as his rehab goals had been met.

During an interview on 03/03/20 at 2:36 PM, the MDS Coordinator #2 confirmed Section A 2100 was coded incorrectly and indicated that Resident #87 was discharged home instead of acute hospital. She explained she was not the MDS Coordinator who responsible to complete this MDS as she had been working for less than 2 weeks. She would correct the error and a modification would be submitted.

During an interview on 03/05/20 at 10:43 AM, the Assistant Director of Nursing (ADON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of recent staff turnover in MDS department. The DON stated it was her expectation for all MDS assessments to be coded accurately.

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 _____	C 03/05/2020

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

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F 641	Continued From page 15	F 641		

During an interview on 03/05/20 at 1:25 PM, the Administrator stated the MDS department required two full time MDS Coordinators to handle the workload. However, due to staff turnover, MDS Coordinator #1 had been working alone in the past 6 months with a part-time MDS Coordinator working for only 6 hours per week. The Administrator attributed the incidents as an oversight due to carelessness. It was her expectation for all MDS assessment to be coded accurately to reflect the clinical needs or conditions of the Resident.

4. Resident #69 was admitted to the facility on 06/09/11 with multiple diagnoses that included atrial fibrosis, cirrhosis, diabetes mellitus, malnutrition, anxiety, and depression.

Review of physician's order dated 02/05/20 revealed an order of hospice consult for weight loss and global geriatric decline was in place.

Review of the Hospice progress notes indicated Resident #69 was started to receive Hospice services for end of life care with an effective date of 02/06/20.

Review of the significant change in status assessment Minimum Data Set (MDS) dated 02/19/20 indicated under Section J-1400 for Prognosis, Resident #69 was not coded with a condition or chronic disease that may result in a life expectancy of less than 6 months. In addition, under Section O for Special Treatments and Programs, it was not coded to indicate Resident #69 received hospice care.

During an interview on 02/25/20 at 2:57 PM, the

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 _____	C 03/05/2020

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

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F 641	Continued From page 16 Social Worker confirmed that the physician had ordered for hospice consult on 02/05/20 and Resident #69 was under hospice care by 02/06/20. During a phone interview on 03/04/20 at 10:11 AM, the MDS Coordinator #1 stated the significant MDS dated 02/19/20 was completed for Resident #69 due to hospice admission and weight loss. She acknowledged that Resident #69 had been under hospice care since 02/06/20 and confirmed Section J 1400 and Section O were coded incorrectly. The MDS Coordinator explained it was an oversight and a modification would be submitted. During an interview on 03/05/20 at 10:43 AM, the Assistant Director of Nursing (ADON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of recent staff turnover in MDS department. The DON stated it was her expectation for all MDS assessments to be coded accurately. During an interview on 03/05/20 at 1:25 PM, the Administrator stated the MDS department required two full time MDS Coordinators to handle the workload. However, due to staff turnover, MDS Coordinator #1 had been working alone in the past 6 months with a part-time MDS Coordinator working for only 6 hours per week. The Administrator attributed the incidents as an oversight due to carelessness. It was her expectation for all MDS assessment to be coded accurately to reflect the clinical needs or conditions of the Resident.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		4/1/20

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 _____	C 03/05/2020

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

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F 657	Continued From page 17 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and physician interviews the facility failed to update a care plan for two of four sampled residents in the areas of discharge plan and nutrition (Residents #11 and 60). The findings include: 1. Resident #11 was admitted on 12/19/19 for	F 657	The facility will continue to ensure care plans are updated timely. Resident #11 and #60 had corrections made to their individual care plans with regard to discharge plans and nutrition at the time of discovery. All residents have the ability to be	

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	345322	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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F 657	Continued From page 18 rehabilitation after sustaining a hip fracture. Review of the care plan dated 12/25/19 revealed a care plan for Resident #11 to return home alone. Interventions included: provision of training for activities of daily living (ADL) that had to be accomplished prior to discharge, home health services were to be set up prior to discharge, and a discharge order from the physician was to be obtained. Review of the Minimum Data Set (MDS) on admission, dated 12/26/19 indicated Resident #11 was moderately cognitively impaired, required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. Resident #11 was receiving physical and occupational therapy and expected to discharge to the community. A progress note dated 2/10/20 by the Nurse Practitioner (NP) indicated that Resident #11 had been asking to go home and the NP did not believe Resident #11 was safe for discharge home. It was noted that Resident #11 still needed assistance with ADL. An interview was completed on 03/02/20 at 12:05 PM with Resident #11 during which Resident #11 reported he was ready to go home and did not understand why the facility would not let him do so. On 03/04/20 at 9:28 AM an interview was completed with the therapy director who indicated that the resident was physically impaired enough that a home environment was unsafe and further stated that Resident #11 was unable to cook, clean, perform	F 657	affected. Beginning 3/10/2020 all resident care plans will transition to an electronic update process and will be accessed electronically, paper care cards will be eliminated. An audit of each individual care plan will occur as each care plan is transferred to the electronic model. Transfer of all records will be complete no later than 4/1/2020. The MDS Coordinator and Assistant were in-serviced by the Clinical Resource Specialist 3/16/2020 on the electronic care plan processes, updates, and accessibility. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON. The DON will randomly audit care plans weekly for 4 weeks, and then randomly for 2 months to ensure that care plans accurately reflect the resident's preferences, needs, and/or requirements. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random care plan audits and through the facility's Quality Assurance Program. The Administrator will convey results to	

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 _____	C 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 19 personal care or manage his medications alone. In an interview with the NP on 03/05/20 at 2:11 PM it was reported that Resident #11 had not shown that he would be able to discharge home on his own due to both cognitive and physical impairments. The NP indicated his new plan was to remain in the facility and this had been the new plan for weeks. An interview was completed with the Social Worker (SW) on 03/04/20 at 11:29 AM. The SW stated that the discussion regarding changing his discharge plan started around 01/22/20 when his coverage for rehabilitation had ended. The SW stated that at that time the Physician and NP discussed the case and felt it was not safe for Resident #11 to discharge home alone. The SW had informed Resident #11 of the decision at that time. The SW stated that it was her responsibility to update the care plan to reflect the change in discharge plan but she had not done so yet because she had not thought about it. On 03/05/20 at 01:29 PM an interview was held with the Assistant Director of Nursing (ADON) who indicated that Resident #11 required more assistance than what could be provided at home and that his new plan was to remain in the facility. The ADON reported that changes to the discharge plan should have been reflected in the care plan in real time. An interview was completed with the Administrator on 03/05/20 at 1:49 PM who indicated that it was her expectation that care plans were to be updated as changes occurred. 2. Resident #60 was admitted on 1/30/20 for	F 657	QA Committee and compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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	345322	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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F 657	Continued From page 20	F 657		

aftercare following gastrointestinal surgery. Additional diagnoses included dementia without behavioral disturbance.

Review of his admission MDS assessment dated 02/10/20 revealed Resident #60 was severely cognitively impaired and required supervision with eating. Resident #60 was coded as having experienced weight loss.

Review of the medical record revealed a care plan dated 02/29/20 which indicated Resident #60 was at risk for nutritional and/or dehydration risk related to a mechanically altered diet with honey thick liquids, impaired cognition and his history of weight loss. Interventions included: dining room for all meals, assistance for completion as indicated.

On 03/03/20 at 8:18 AM resident #60 was observed lying in bed with his eyes closed, his breakfast tray was on the bedside table and none of the meal had been consumed.

On 03/04/20 at 08:12 AM Resident #60 was observed in his room with his meal tray. None of his meal had been consumed, Resident #60 was sitting up in his bed fidgeting with a sugar packet.

On 03/05/20 at 8:45 AM resident #60 was observed eating his breakfast in his room. He was eating independently, sitting up in his bed, in a good position to eat.

In an interview on 03/04/20 at 11:45 AM with Nursing Aide (NA) #1, it was reported that Resident #60 ate in his room most of the time. NA #1 stated that staff would try to encourage him to go to the dining room but he often refused. NA #1

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 _____	C 03/05/2020

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

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F 657	Continued From page 21	F 657		

did not know that Resident #60 had a care plan to eat his meals in the dining room but reported that she could find that information on the care card (a sheet used to inform staff member of resident needs and assistance level required for ADL care) in his closet.

An interview was held on 03/04/20 at 11:49 AM with NA #2 who stated that Resident #60 ate the majority of his meals in his room. NA #2 reported that she would sometimes try to encourage him to go eat in the dining room, but he preferred to eat in his room and would often decline to go to the dining room. NA #2 was not aware that Resident #60's care plan indicated he was to eat his meals in the dining room because the care card (which was supposed to reflect the care plan) indicated Resident #60 preferred to eat his meals in his room.

An interview was completed with the MDS Assistant on 03/04/20 at 11:36 AM who reported that she and the MDS Director were responsible for managing the care plans and keeping them up to date. The MDS Assistant reported that if the care plan was not being followed staff would need to let her know so it could be updated.

An observation was made of the care card in Resident #60's closet with the MDS Assistant on 03/04/20 at 11:40 AM which indicated Resident #60's preference was to eat his meals in his room. The care card was updated on 02/07/20.

An interview with the MDS Assistant was conducted on 03/04/20 at 11:40 AM who indicated that this was a discrepancy as the care card was supposed to reflect the care plan. The MDS Assistant further reported it was the

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 _____	C 03/05/2020

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

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F 657	Continued From page 22 responsibility of MDS staff to keep the care plans and care cards up to date. On 03/05/20 at 01:29 PM an interview was held with the Assistant Director of Nursing (ADON) who indicated that Resident #60 generally ate his meals in his room. The ADON stated that the care plan should have been updated. An interview was completed with the Administrator on 03/05/20 at 1:49 PM who indicated that Resident #60 preferred to eat his meals in his room and his care plan should have been updated.	F 657		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not	F 725		4/1/20

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 _____	C 03/05/2020

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

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F 725	Continued From page 23 limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews, the facility failed to maintain sufficient nursing staff to ensure residents received showers for 2 of 3 residents reviewed for choices (Residents #62 and #64). Findings included: This tag is cross-referenced to: F-561: Based on record review, resident and staff interviews, the facility failed to provide showers as scheduled for 2 of 3 residents reviewed for choices (Resident #62 and #64). During an interview on 03/03/20 at 8:36 PM Nurse #1 stated that since approximately December 2019 they had worked short-staffed, "more often than not." Nurse #1 reported every night she worked, residents voiced to her that they did not receive their scheduled shower and she had noticed residents were complaining more frequently about staff taking too long to answer call lights and having to wait for incontinence care to be provided. Nurse #1 explained it was difficult for staff to provide timely care when short-staffed and added when working short-staffed, staff had to focus on meeting the basic care needs of the residents. In addition, Nurse #1 reported staff weren't able to provide frequent redirection/intervention to residents with	F 725	Cross referenced to tag F561. The facility will maintain sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to patients. Resident #62 and #64 shower schedules/preferences have been discussed individually and preferences documented within the electronic task record. All residents in the facility have the potential to be affected. No negative outcome was identified relating to this observation. The facility has provided in-servicing to staff on 3/13/2020 giving resident care with the ability to document activities of daily living to ensure care is documented, specifically shower documentation/charting. A QA monitoring tool will be created for: Documentation/charting audits performed weekly for 12 weeks. Audits of shower documentation will reflect care has been provided for each guest as requested. Additionally, a staff monitoring tool will be created as a tracking tool for nursing department staffing ratios and used as an indicator of insufficient staffing levels. The	

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	345322	A. BUILDING _____ B. WING _____	C 03/05/2020

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F 725	Continued From page 24 wandering behaviors and stated, "we usually just have to let the residents wear themselves out" prior to assisting them to bed. Nurse #1 shared she tried to assist the Nurse Aides (NAs) as much as she could, which often put her behind on completing the medication pass. Nurse #1 reported that despite the Administration's efforts to fill the open positions, staffing had not gotten any better because the new employees they had hired didn't stay. During an interview on 03/03/20 at 9:00 PM Nurse #2 was unable to recall the specific dates but confirmed there was a period of time when showers were not provided to the residents as scheduled due to the facility being short-staffed. Nurse #2 explained around tax time the facility usually had a staffing shortage due to staff turnover and recently the facility offered NAs incentive bonuses to work extra shifts. During an interview on 03/04/20 at 9:44 AM, the Rehab Director (RD) confirmed when the facility was short-staffed, Rehab Staff (RS) had pitched in to assist residents, who were not on therapy case load, with getting showers but stated it was not on a consistent basis. The RD recalled 2 recent occasions, approximately 2 to 3 days in November 2019 and one weekend in February 2020, when RS had assisted with resident showers because the facility was short-staffed. The RD explained rehab staff were not placed on the facility staffing schedule to provide resident showers and only assisted as their therapy schedule allowed. During an interview on 03/04/20 at 11:15 AM, Nurse Aide (NA) #6 revealed they had worked short-staffed since approximately December	F 725	DON will oversee weekly shower audit and report results to the Administrator each month for 3 months. The Administrator will oversee staff monitoring tool four times a week for the next 12 weeks. Continued compliance will be monitored through random documentation/charting audits, the daily staff monitor, and the facility's Quality Assurance Committee. The Administrator will convey results to QA Committee and compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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F 725	Continued From page 25	F 725		

2019 and as a result, staff had not been able to provide residents with their scheduled showers twice a week. NA #6 added that even though it wasn't the same as a shower, she tried to at least give the resident "a good bed bath" but even that was not always possible when short-staffed.

During an interview on 03/04/20 at 11:18 AM, Nurse #3 shared the facility had been short of NAs since approximately December 2019. Nurse #3 explained when working short-staffed, the shower aides were pulled to the floor to provide resident care and staff were not able to provide residents with their scheduled showers.

During an interview on 03/05/20 at 2:01 PM, NA #7 shared that for the past few months, she was regularly pulled from the shower team to work the floor due to staffing shortage. NA #7 explained when short-staffed, they had to prioritize resident care with the focus on keeping the residents clean and dry. NA #7 stated she made every effort to give a resident their shower when needed but when short-staffed, showers weren't always able to be provided.

During an interview on 03/05/20 at 2:25 PM, NA #8 revealed staffing had been challenged and shower aides were often pulled to work the floor which left no one available to provide resident showers. NA #8 added she focused on resident care and was never instructed to give resident showers when there was no designated shower aide for the hall.

During an interview on 03/05/20 at 12:38 PM, the Corporate Nurse Consultant (CNC) revealed the facility had identified the issue with residents not receiving showers as scheduled due to staffing

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F 725	Continued From page 26	F 725		

challenges. She explained members of the Resident Council had voiced concerns they were not receiving their showers as scheduled and in an effort to address the issue, the facility had paid for staff to work extra hours to help provide resident showers. The CNC added they had not put an action plan in place to address showers because they felt the issue was improving.

During a joint interview on 03/05/20 at 8:54 AM, the Assistant Director of Nursing (ADON) explained based on the current resident census and acuity needs, the preferred NA minimums per day were: 5 NAs 7:00 AM to 7:00 PM, 6 NAs 7:00 AM to 3:00 PM, 5 NAs 3:00 PM to 11:00 PM, 4 NAs 11:00 PM to 7:00 AM, and 3 shower aides 7:00 AM to 3:00 PM Monday through Friday which she felt was sufficient to meet the residents needs provided there were no call-outs. The ADON confirmed due to the staffing challenges they currently faced, it was difficult to meet their preferred minimums. She was aware residents were not receiving their showers as scheduled and stated they were doing all they could to recruit new staff but have had difficulty finding NAs to fill the open positions. She added staff were good to pick up extra hours and when the shower aides were pulled to work the floor, they tried to make up the showers that were missed but stated they currently did not have a system in place to track residents who did not receive their scheduled shower. The ADON stated at first they thought hiring more staff would fix the issue but it had not helped as much as they had hoped and the system was still broken.

During a joint interview on 03/05/20 at 8:54 AM, the Administrator confirmed the facility faced a staffing challenge and stated their recruitment

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F 725	Continued From page 27 process remained ongoing. She explained in an effort to attract more applicants, they had ongoing job advertisements posted on Indeed, attended sessions a local community college to recruit new graduates, sponsored hiring events at the Chamber of Commerce, and offered sign-on bonuses. In addition, they had paid for Hospitality Aides to attend a NA certification course at a local community college, offered a Med Aide training class to select NAs, offered incentive bonuses to current staff, and increased the wage scale. She stated despite their best efforts, they still had a hard time finding NAs to fill the open positions. The Administrator stated they were working on a new staffing model that would utilize more Med Aides who would also work as NAs in an effort to redistribute the work load which they felt would reduce the number of open positions needed and alleviate the shortage of staff.	F 725		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review of the Facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 04/18/19 annual recertification survey. This was for one recited deficiency in the areas of accuracy of assessments (F 641). This deficiency was cited	F 867	F867 QAPI/QAA Improvement Activities The facility will continue to ensure that the Quality Assessment and Assurance Committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops	4/1/20

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F 867	Continued From page 28 again on the annual recertification survey on 03/05/20. This continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA programs. Findings included: This tag is cross referenced to: F 641-Accuracy of Assessments: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Sets (MDS) in the areas of medications, discharge status, hospice and prognosis for 4 of 10 residents reviewed for resident assessments, choices, closed records, and unnecessary medications (Resident # 82, #44, #87, and #69). During the recertification survey on 04/18/19 the facility was cited for F 641 for failure to accurately code the MDS for antipsychotic use in 1 of 5 residents reviewed for unnecessary medications. On 03/05/20 at 2:41 PM an interview was conducted with the Administrator who also headed the QAA committee. The Administrator indicated the MDS department had previously been understaffed for six months which left the remaining employee with a heavy workload to complete without assistance. The Administrator shared that the facility recently added an additional MDS nurse to assist the MDS Coordinator with MDS assessments.	F 867	and implements appropriate plans of action to correct identified quality deficiencies. The facility will continue to code MDS assessments accurately to reflect a patient's medications, discharge status, hospice and prognosis, choices, unnecessary medications, and anti-psychotic use. All errors were corrected at the time of discovery and re-submitted as required. The MDS Coordinator and Assistant were in-serviced by the Clinical Resource Specialist on 3/16/2020 completing assessments that accurately reflect the resident's disposition. The facilities quality assurance committee will be inserviced by the Regional QA Manager/Regional Operator on the procedures for developing and implementing appropriate plans of action to correct identified quality concerns. Education will include determining the root cause of the identified concern, identifying, implementing, and monitoring the corrective action plan and recognizing when an action plan may need to be revised. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON. The DON will randomly audit MDS assessments weekly for 4 weeks, and then randomly for 2 months to ensure that MDS assessments are being completed that accurately reflect the resident's	

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F 867	Continued From page 29	F 867	disposition. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meeting. A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional QA Manager/Designee. The Regional QA Manager/ Regional operator will attend the facility quality assurance meeting monthly for two months to ensure committee is developing and implementing appropriate plans of action to correct quality concerns. Variances will be corrected and/or additional education provided when indicated. The Administrator will convey results to QA Committee and continued compliance will be monitored through the facility's Quality Assurance Committee.	