STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 01/29/25 to conduct an unannounced complaint investigation. The survey team was onsite 01/29/25 and 01/30/25. Additional information was obtained offsite on 01/31/25 and 02/05/25. Therefore, the exit date was changed to 02/05/25. Event ID# LS4K11. The following intakes were investigated: NC00226516 and NC00226555. 2 of 2 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.12 at tag F604 at a scope and severity of (J). CFR 483.12 at tag F607 at a scope and severity of (J). The tags F604 and F607 constituted Substandard Quality of Care.	F 000		
F 604 SS=J	A partial extended survey was conducted. Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse,	F 604		

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

Electronically Signed 02/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 1 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, photographic evidence review, and staff, Law Enforcement Officer, Wound Nurse Practitioner, and Medical Doctor interviews, the facility failed to protect a vulnerable resident's right to be free from physical restraints when Resident #1 was found with socks placed on each hand and held in place by rubber bands wrapped around each wrist for 1 of 3 residents reviewed for restraints (Resident #1). On 01/27/25 at approximately 12:00 AM, Resident #1 was observed with socks covering each hand that were secured with rubber bands wrapped around each wrist, effectively forming tourniquets (device often used in emergency situations to apply pressure to a limb or extremity to stop blood flow) on her wrists, but not in a controlled manner. Her hands appeared larger than normal through the socks and the rubber bands had to be cut in order to remove the socks	F 604	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 2	F 604		

from Resident #1's hands. Resident #1's right hand was edematous (abnormally swollen due to an accumulation of fluid in the bodies tissues) and bright red in appearance. There were several blisters on the top of the hand, a large fluid filled blister in the palm of the hand with some drainage and a red ligature (visible indentation left on the skin) mark around the right wrist. Resident #1 was evaluated by the Wound NP on 01/27/25 who noted the blister on the palm of Resident #1's right hand measured 17 centimeters (cm) by 20 cm by 0 cm and ordered wound treatment to be applied daily. The reasonable person concept was applied to this deficiency as a reasonable person would not expect to have socks placed on their hands preventing them from freely moving their fingers or using their hands and would experience pain from rubber bands wrapped tightly around their wrists to hold the socks in place.

Findings included:

Resident #1 was admitted to the facility on 07/31/24 with diagnoses that included Alzheimer's disease, dementia and multiple sclerosis (a chronic disease that affects the central nervous system).

The quarterly Minimum Data Set (MDS) assessment dated 11/07/24 assessed Resident #1 with severe impairment in cognition. She required total staff assistance for all self-care tasks, mobility and transfers. She had no impairment in her upper or lower extremities and displayed no behaviors or rejection of care. The MDS noted Resident #1 weighed 97 pounds, had no unhealed pressure ulcers or other skin conditions, received hospice care, and used no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 3	F 604		

restraints.

A care plan last revised on 11/14/24 revealed Resident #1 had a behavior problem of coprophagy (eating feces). Interventions included for staff to intervene as necessary, divert attention, monitor and provide hygiene care as needed. The care plan did not include any intervention to apply socks and/or rubber bands to her hands.

Review of the physician orders for Resident #1 revealed no order for restraints or the application of socks or rubber binding to her hands and/or wrists.

A Situation, Background, Assessment and Response (SBAR) summary note written by Nurse #1 on 01/27/25 at 12:30 AM revealed in part, Resident #1 had socks on both hands for protection from scratching and digging. The socks were removed to assess the skin and Resident #1's hands were swollen with serum (clear, watery liquid) blisters to the right hand. The on-call provider and Director of Nursing (DON) were notified.

A telephone interview was conducted with Nurse #1 on 01/29/25 at 1:48 PM. Nurse #1 revealed she was employed by the facility and verified she was assigned to provide Resident #1's care on Sunday 01/26/25 to Monday 01/27/25 during the hours of 11:00 PM to 7:00 AM. Nurse #1 recalled around 12:30 AM, Nurse Aide (NA) #1 came to let her know that Resident #1 was found with socks on her hands, rubber bands around her wrists and her hands were swollen. Nurse #1 stated she immediately went to assess Resident #1, NA #1 had already removed the sock and rubber

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 4	F 604		

bands off Resident #1's right hand and Nurse #1 stated she cut the sock and rubber bands off Resident #1's left hand. Nurse #1 recalled Resident #1's right hand was swollen, blistered and red and her left hand was swollen but not blistered. Nurse #1 notified the DON, called the on-call provider and while waiting for a return phone call from the on-call provider, she went ahead and provided treatment to Resident #1's right hand. Nurse #1 stated she looked through Resident #1's medical records and did not see any physician orders for socks to be placed on her hands and there was no intervention in her care plan either. Nurse #1 explained Resident #1 would play in her feces on occasion and she could only assume that was why someone had placed the socks and rubber bands on her hands; however, that was not an intervention the facility typically used. She did not know who applied the socks or rubber bands on Resident #1's hands or how long they had been in place. Nurse #1 stated during her assessment, Resident #1 did not display signs or symptoms of pain as she had just received her scheduled morphine (pain medication) earlier that evening. Nurse #1 stated no one had mentioned anything to her about the socks and rubber bands observed on Resident #1's hands until it was brought to her attention by NA #1.

A telephone interview was conducted with Nurse Aide (NA) #1 on 01/29/25 at 1:21 PM. NA #1 revealed she was employed by the facility and verified she was assigned to provide Resident #1's care on Sunday 01/26/25 to Monday 01/27/25 during the hours of 11:00 PM to 7:00 AM. NA #1 recalled she was doing her initial incontinence rounds when she first went in to check on Resident #1 around 12:00 AM. When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 5	F 604		

she went into Resident #1's room and pulled back the covers she observed socks on both of Resident #1's hands that were being held in place by rubber bands. NA #1 stated she thought the rubber bands had been wrapped around Resident #1's wrists at least twice. She stated she could tell Resident #1's hands were swollen even with the socks on because her hands were pressed tightly against the socks and looked much bigger than they should have been. She explained Resident #1's hands were so large, she was not able to pull the socks or rubber bands off and had to cut them in order to remove them from Resident #1's hands. NA #1 stated she started with the right hand and once the sock was removed, she immediately noticed Resident #1's right hand was very swollen, the skin of her hand and wrist was bright red in appearance and there were red marks around her wrist where the rubber bands had been that started to bruise. Resident #1 also had several blisters on top of the right hand and a large blister covering the palm of her right hand that were leaking. NA #1 stated she immediately informed Nurse #1 and when Nurse #1 came to the room to assess Resident #1 she instructed NA #1 to cut the rubber bands and sock off the left hand. NA #1 recalled Resident #1's left hand was also swollen but less red in appearance with no blisters that she recalled and there were red marks around Resident #1's left wrist where the rubber bands had been. NA #1 was not sure who put the socks and rubber bands on Resident #1's hands but recalled staff mentioning in the past that Resident #1 messed with her feces; however, NA #1 had never witnessed Resident #1 display that type of behavior. NA #1 stated if Resident #1 had messed in her feces when she provided her care, she would have just cleaned her up and would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 6	F 604		

never have placed socks and/or rubber bands on her hands to deter the behavior because it would be considered a restraint.

A Wound Nurse Practitioner (NP) progress note dated 01/27/25 revealed in part, Resident #1 was seen for a new skin and wound consult. The Wound NP noted facility staff reported Resident #1 had a new blister on the right hand that was caused by socks being secured on her hands. The Wound NP's assessment revealed Resident #1 had a new nonthermal (raised, fluid-filled pocket on the skin that is not caused by heat or burns) blister on the right hand with partial thickness (forms on the skin between the top and middle layer of skin) and measured 17 cm by 20 cm by 0 cm. The periwound (area of skin surrounding the blister) was noted as fragile with erythema (redness of the skin) and edema (swelling). The Wound NP provided recommendations for wound treatment, to notify the Wound NP or provider when the blisters ruptured and become an open wound and to not place/secure socks or any dressing/covering tightly on Resident #1's hand or anywhere on the extremities that could restrict blood flow.

A telephone interview was conducted with the Wound NP on 01/30/25 at 3:31 PM. The Wound NP stated when he evaluated Resident #1 on 01/27/25, she had multiple fluid-filled blisters on the dorsal (part of the hand where the knuckles are located) side of the hand and a large blister on the palm of her hand. He stated from what the blisters looked like when he evaluated Resident #1, the damage from the blisters seemed superficial and he left the blisters intact to let them heal naturally. The Wound NP stated the binding used on Resident #1's wrists to keep the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 7	F 604		

socks on her hands was what caused the blisters and swelling.

A Medical Doctor (MD) progress note dated 01/27/25 read in part, Resident #1 was seen to evaluate blisters on her right hand. The MD noted socks were placed on both hands, secured with rubber bands, to prevent Resident #1 from scratching certain parts of her body which sometimes gathered fecal matter and the right rubber band was much tighter than the left and it was unclear exactly how long the rubber bands had been on Resident #1's wrists. When the socks were removed, there was an extensive amount of blisters noted to the right hand. The MD assessment revealed Resident #1's right hand had large, raised blisters on the palmer (palm) surface and dorsal surface that did not look indurated (hardening and thickening of the skin) and there was no black eschar (dead tissue) or skin discoloration. Resident #1 had good distal vascularity (blood flow in the extremities) and was moving all fingers without difficulty. There was some non-pitting edema noted around the wrist area and the rubber band mark just below the wrist was barely noticeable. The MD cleaned the blisters with alcohol, used a sterile needle to puncture the blisters and clear serous (watery) fluid drained from the blisters. A topical antibiotic cream and gauze dressing was applied to Resident #1's right hand. Resident #1's left hand had a small blister measuring one (1) cm along the thenar eminence (area of the palm at the base of the thumb) with no discoloration or induration noted. Resident #1 was able to move all the fingers of the left hand without difficulty and had good distal vascularity. The blister was drained using a sterile needle and dressing applied.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 8 During an interview on 01/29/25 at 4:20 PM and follow-up telephone interview on 01/29/25 at 5:33 PM, the MD stated when he assessed Resident #1 on 01/27/25 she had fluid-filled blisters on the top of the right hand and a large blister on the palm of the right hand that appeared superficial with no black eschar or signs of infection. When he cleansed and punctured the blisters there was no tinge of blood in the serous fluid drainage. He stated Resident #1 had good range of motion in her fingers, good capillary refill (clinical test that assesses the speed of blood flow through the capillaries) and no arterial compromise (condition that occurs when blood flow to an area of body is reduced or blocked) when he checked her wrist pulse. The MD stated when he evaluated Resident #1 again on 01/28/25, she had no blister reformation or skin infection and she still had a very good pulse and was moving her fingers. He stated it was going to take some time but her injuries were improving. He explained the rubber bands placed on Resident #1's wrist did not decrease blood flow as circulation was there but the rubber bands did decrease the venous flow (movement of blood from the hand back to the heart) which backed up into the lymphatic flow (extra fluid that drains from cells and tissues in the body that isn't reabsorbed into the capillaries) causing the blisters. The MD expressed it was difficult to determine how long the socks and rubber bands had been in place on Resident #1's hands and wrists; however, without the binding (referring to the rubber bands) around Resident #1's wrists, there would have been no blisters. During an interview on 01/29/25 at 11:50 AM, the investigating Law Enforcement Officer revealed in addition to law enforcement he also had an	F 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 9	F 604		

extensive medical background that included Medical Examiner and forensic pathology. The Law Enforcement Officer stated he observed Resident #1's hands on 01/27/25 and 01/28/25 and took photos of the injuries. The Law Enforcement Officer stated when he observed Resident #1's hands on 01/27/25, her right hand was wrapped in a gauze dressing. Her right hand was almost degloved (type of traumatic injury that involves the skin and soft tissue being torn away from the muscle and connective tissue underneath) and there were red ligature marks on both the right and left wrists. In addition, Resident #1 had a raised blister on the palm of the right hand that he estimated to contain 50 cc (cubic centimeters) of fluid. On 01/28/25, when he observed Resident #1's right hand again with the gauze dressing removed, the MD had already decompressed the blisters. Her right hand and wrist were red and swollen from the wrist to the fingers which he felt was suggestive of cellulitis (bacterial infection of the skin) and there were long strands of skin hanging off the palm. There were no blisters or significant swelling on her left hand but she did have a red ligature mark around her wrist. The Law Enforcement Officer stated he was informed by the facility that rubber bands had been placed around her wrists to hold the socks in place on her hands. The Law Enforcement Officer stated he was currently conducting an investigation.

Photographs taken of Resident #1's hands and wrists received via email correspondence dated 01/28/25 from the investigating Law Enforcement Officer were reviewed. In the first three photographs taken on 01/27/25, Resident #1's hand was covered in a gauze dressing and when the dressing was pulled back, the index finger

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 10	F 604		

was outside of the dressing and appeared swollen. The middle and ring fingers were bent inside the gauze dressing and you could partially visualize a raised fluid-filled blister starting at the base of the middle and ring fingers leading down the top of the hand. When the dressing was moved to visualize the wrist, the skin was red with a blister and indentation mark on the inside of the wrist where the rubber bands had been. The remaining pictures taken on 01/28/25, revealed the skin on Resident #1's right hand was red from the wrist to the fingers and there was peeling skin on the top and palm. Her left hand and palm had minimal redness with no blisters and a red mark on the wrist.

During a follow-up interview on 01/29/25 at 4:09 PM, the investigating Law Enforcement Officer stated he spoke with NA #1. NA #1 sent him photographs she took on 01/27/25 of the socks and rubber bands on Resident #1's hands and wrists. He stated the pictures clearly showed Resident #1's wrists had two rubber bands bound tightly around her wrists.

Photographs of Resident #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 investigating Law Enforcement Officer were reviewed. There were three photographs in total. In the first photograph, both of Resident #1's hands were covered in grayish/tan gripper socks. The left hand was more prominent in the photograph and showed two rubber bands, approximately 1/8 of an inch in width, wrapped around the wrist twice and her hand above the wrist appeared 2 to 3 times its normal size in the sock. Her chin was resting on the right hand and the rubber bands were not visible but you could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 11	F 604		

visualize how large her hand appeared in the sock. In the second photograph, the sock and rubber bands had been removed from the right hand and her palm was facing upward. There were red ligature marks on the lower part of the inside of her wrist. The skin on her wrist, hand and fingers were visibly swollen and bright red in appearance. There was a large, raised fluid-filled blister from the edge of the palm to the bend of her fingers that covered the width of the palm. The sock was still on her left hand and you could visualize a rubber band, approximately 1/8 of an inch in width, bound twice around her wrist. In the third photograph, was a left sided view of Resident #1's right hand that was facing upward and tilted slightly. There was a purple colored, bruised area on the outer wrist along the red ligature mark. The skin from the wrist to the fingers were bright red and swollen 2 to 3 times its normal size, resembling a lobster claw. Just underneath the outer edge of the top of the hand were two raised fluid-filled blisters at the base of the hand and a fluid-filled blister at the bend of the ringer finger to the knuckle.

A telephone interview was conducted with Nurse #2 on 01/29/25 at 4:59 PM. Nurse #2 revealed she was employed by a staffing agency and verified she was assigned to provide Resident #1's care on Friday 01/24/25 during the hours of 7:00 AM to 3:00 PM. Nurse #2 did not recall noticing socks or rubber bands on Resident #1's hands or wrists.

A telephone interview was conducted with NA #2 on 01/29/25 at 12:10 PM. NA #2 revealed she was employed by a staffing agency and verified she was assigned to provide Resident #1's care on Friday 01/24/25, Saturday 01/25/25 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 12	F 604		

Sunday 01/26/25 during the hours of 7:00 AM to 3:00 PM. NA #2 stated she could not honestly recall noticing if Resident #1 had socks or rubber bands on her hands or wrists on 01/24/25 but she did notice the socks on Resident #1's hands when she started her shifts on 01/25/25 and 01/26/25. She explained the socks were placed neatly around Resident #1's hands and she left them on her hands thinking they had been put there by the previous shift as an intervention to keep her from messing in her feces. When asked what she meant by the socks being neatly placed on Resident #1's hands, she stated the socks were pulled down to the tips of the fingers and covered her hand but did not recall them appearing to be tight. NA #2 stated she did not recall noticing any rubber bands around Resident #1's wrists holding the socks in place and felt she would have seen them if they had been there. NA #1 expressed that it was possible the rubber bands could have been folded up in the socks and she just didn't notice.

A telephone interview was conducted with NA #3 on 01/30/25 at 2:42 PM. NA #3 revealed she was employed by a staffing agency and verified she was assigned to provide Resident #1's care on Friday 01/24/25 to Saturday 01/25/25 during the hours of 4:30 PM (she arrived late to work) to 7:00 AM and again on Sunday 01/26/25 during the hours of 3:00 PM to 11:00 PM. NA #3 recalled on 1/24/25 she was assigned to the left side of 500 Hall (side where Resident #1 resided) and NA #4 was assigned to right side of 500 Hall. NA #3 recalled on 01/24/25 Resident #1 was observed eating her feces after an incontinence episode. She could not remember the exact time but stated at one point during the shift, NA #4 had assisted her with cleaning up Resident #1. NA #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 13	F 604		

recalled Resident #1 had socks on her hands that were removed and after care was provided, NA #4 placed new socks back on Resident #1's hands. At that point, NA #3 stated she went to assist Resident #1's roommate while NA #4 left the room. When NA #4 returned, she noticed he had rubber bands in his hands and he went around the privacy curtain to Resident #1. NA #3 stated she did not see NA #4 place the rubber bands around Resident #1's wrists but knew that he had because the rubber bands were on Resident #1's wrists when she checked on her again later in the shift. NA #3 explained she thought that was strange when NA #4 put the socks on Resident #1's hands but he told her "that's just what they do" and she just assumed that was facility protocol to try and keep Resident #1 from messing in her feces. NA #3 stated she knew that the use of the socks and/or rubber bands on Resident #1's hands were considered a restraint and she didn't question NA #4 further because he was sort of training her and seemed to know the residents well. NA #3 stated she honestly did not think the socks or rubber bands would harm Resident #1 and didn't think much about it the remainder of the shift because it was a busy night. NA #3 recalled when she started her shift on 01/26/25, Resident #1 still had the same socks on both her hands along with the rubber bands around her wrists that were put on 01/24/25 by NA #4. NA #3 could not recall how the socks looked when she started her shift on 01/26/25 or how Resident #1's hands and wrists appeared with the socks in place. NA #3 explained she really wasn't paying attention to how Resident #1's hands presented on 01/26/25 because most of the shift Resident #1 was sleeping on her hands or her hands were under the cover and she couldn't say for sure whether

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 14	F 604		

Resident #1's hands appeared larger than normal or swollen. NA #3 restated she knew for a fact that the socks and rubber bands were placed on Resident #1's hands by NA #4 01/24/25 and indicated everyone who worked with Resident #1 since that date would have seen the socks and rubber bands but they all dropped the ball, herself included.

A telephone interview was conducted with NA #4 on 01/31/25 at 1:59 PM. NA #4 revealed he was employed by a staffing agency and verified he worked on Friday 01/24/25 during the hours of 3:00 PM to 11:00 PM on Resident #1's hall with NA #3. He explained NA #3 was assigned to provide care to the residents on the left side of 500 Hall where Resident #1 resided and he was assigned to provide care to the residents on the right side of the hall. NA #4 stated it was sometime after supper between 7:00 PM and 8:00 PM when he went to assist NA #3 with cleaning up Resident #1 after she had an incontinence episode. NA #4 recalled when he and NA #3 went into Resident #1's room he noticed that she was eating her feces and she had feces all over her body, mouth and inside of her mouth. NA #4 stated he did not notice Resident #1 with any socks or rubber bands on her hands or wrists when he used facility wipes to clean her hands, fingers and nails and he did not put any socks or rubber bands on her hands when he was done. NA #4 stated after cleaning Resident #1's hands, he assisted NA #3 with giving Resident #1 a bed bath, changed the bed linens and then he left the room. He stated he did not go back in Resident #1's room the remainder of the shift. NA #4 stated he knew people were aware that Resident #1 would eat her feces on occasion because when he started

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 15	F 604		

at the facility approximately a year ago, he had noticed her with socks on her hands and when he asked staff about it they told him the socks were placed on her hands to keep her from messing in her feces and/or eating her feces. When NA #4 was asked who had told him that information, he could not recall the names and stated they were agency staff. NA #4 explained anytime he had an assigned residents that would dig in their briefs, he just cleaned them up, usually gave them a shower or bed bath, and never put socks or rubber bands on their hands. NA #4 restated he did not observe or place any socks and rubber bands on Resident #1's hands and wrists when he assisted NA #3 on 01/24/25 and was not sure who did.

During a follow-up telephone interview on 02/05/25 at 3:01 PM, the investigating Law Enforcement Officer stated he had received a text message from NA #3 that she had sent to NA #4 prior to the Law Enforcement Officer's interview with NA #3 on 01/30/25. A summarization of the text message revealed NA #3 informed NA #4 that everyone thought she had placed the rubber bands and socks on Resident #1's hands and she would not take the fall for him over something he did.

A telephone interview was conducted with Nurse #3 on 01/30/25 at 3:04 PM. Nurse #3 revealed she was employed by the facility and verified she was assigned to provide care to Resident #1 on Saturday 01/25/25 and Sunday 01/26/25 during the hours of 7:00 AM to 7:00 PM. Nurse #3 stated on 01/25/25, Resident #1 was in bed most of the day covered with a blanket and she didn't recall noticing Resident #1's hands. On 01/26/25, Nurse #3 stated she saw the socks on both of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 16	F 604		

Resident #1's hands but did not see any rubber bands. She stated she did not remove the socks from Resident #1's hands to observe the skin and explained the socks did not seem tight or swollen and there was no redness to her arms that she recalled. Nurse #3 stated she didn't question why the socks were placed on Resident #1's hands because she knew that Resident #1 would play in and eat her feces and no one had brought any concerns regarding the socks to her attention.

A telephone interview was conducted with NA #5 on 01/30/25 at 10:08 AM. NA #5 revealed she was employed by the facility and verified she worked on Saturday 01/25/25 during the hours of 7:00 AM to 3:00 PM 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 Resident #1 resided and she was assigned to provide care to the residents on the right side of the hall. NA #5 recalled sometime right after lunch, NA #2 asked her to pull Resident #1 up in bed and when she did, she noticed Resident #1 had socks on each hand with one rubber band around each wrist that was holding the socks in place. NA #5 stated she did not notice anything unusual about how her hands looked with the socks on nor did she recall noticing any signs of swelling or redness on the visible skin. NA #5 expressed she did not question why Resident #1 had socks and rubber bands on her hands, did not remove them and just assumed the socks were put on for a reason.

A telephone interview was conducted with NA #6 on 01/30/25 at 11:32 AM. NA #6 revealed she was employed by a staffing agency and verified she was assigned to provide care to Resident #1 on Saturday 01/25/25 to Sunday 01/26/25 during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 17	F 604		

the hours of 3:00 PM to 7:00 AM. NA #6 recalled when she started her shift on 01/25/25, Resident #1 had had socks on her hands with one (1) rubber band wrapped around each wrist holding the socks in place. She explained the rubber bands were slid over the wrist, not wrapped twice or tight, and described it like someone who would put a hair tie on their wrist loosely in case they wanted to pull their hair up. NA #6 stated usually the nurses were the only ones that had rubber bands and she just assumed the nurses had put the socks and rubber bands on Resident #1's hands and wrists for a particular reason and didn't ask anyone about it. NA #6 stated she assumed it was standard protocol because she was told that Resident #1 liked to dig in her bottom and play with/eat her fecal matter. NA #6 revealed she also worked on Sunday 01/26/25 to Monday 01/27/25 during the hours of 11:00 PM to 7:00 AM and had gone into the room with NA #1 to check on Resident #1. NA #6 recalled there were rubber bands wrapped around Resident #1's wrist "multiple" times to hold the socks in place and even with the socks on her hands, you could see that Resident #1's hands were huge. NA #6 stated NA #1 had to cut the rubber bands off of Resident #1's wrist and she had blisters on her hands that had leaked through the socks onto the bed linens. NA #6 stated NA #1 immediately informed Nurse #1 who came and assessed Resident #1. NA #6 restated she did not question or ask why Resident #1 had socks and rubber bands on her hands and wrists on 01/25/25 and was not sure who put them on Resident #1's hands.

Unsuccessful telephone attempts were made on 01/29/25 at 1:12 PM and 01/31/25 at 10:18 PM for an interview with Nurse #4 who was employed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 18	F 604		

by a staffing agency and was assigned to provide Resident #1's care on Saturday 01/25/25 during the hours of 7:00 PM to 7:00 AM.

During interviews on 01/29/25 at 3:42 PM and 01/30/25 at 9:40 AM, the Director of Nursing (DON) revealed she received a call from Nurse #1 on 01/27/25 around 1:15 AM informing her that she (Nurse #1) had observed socks on both of Resident #1's hands with rubber bands placed tightly around her wrists, both hands were swollen and the right hand had blisters. The DON recalled when she arrived at the facility around 1:35 AM, Nurse #1 had already provided wound care and bandaged Resident #1's hand. When the DON removed the bandages from Resident #1's hand, both hands were pink and swollen and the right hand had several blisters on the top part of the hand and one large blister covering the palm of the right hand. The DON stated during the assessment, she did not notice any indentation from the rubber bands on Resident #1's wrists due to all the swelling and Resident #1 did not display any signs or symptoms of discomfort or pain. The DON stated she called the Administrator to inform him of the incident and then started an investigation. She stated Resident #1 was evaluated by the MD 01/27/25, he started Resident #1 on an antibiotic prophylactically (treatment taken to prevent or protect against infection) and provided orders for wound treatment twice a day. The DON recalled the MD stating based on the extent of Resident #1's injuries, the rubber bands had been on her wrists for less than 7 hours and if they had been in place any longer, there would have been more cell death. She stated when she spoke with Resident #1's Responsible Party (RP) on 01/27/25 to inform the RP of what had occurred,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 19	F 604		

the RP reported being aware that socks were being put on Resident #1's hands because she played with her feces and was ok with them being used. She explained to Resident #1's RP that type of intervention was not something the facility would use as it was considered a restraint. The DON verified socks placed on the hands and secured with rubber bands was never an appropriate intervention to use on any resident and facility hired and agency staff were informed during orientation that restraints were not something the facility used.

During an interview on 01/30/25 at 4:44 PM, the Administrator recalled he woke up around 5:30 AM on 01/27/25 and noticed he had missed a call from the DON. He called the DON and she informed him of the incident involving Resident #1. When asked what he was told by the DON, he stated at that point she was describing the aftermath, basically the extent of Resident #1's injuries. The Administrator stated when he arrived at the facility and observed Resident #1's hands, she still had a good deal of swelling in the right hand and the right hand was red and blistered. Resident #1's left hand was a little less red and swollen with no blisters. The Administrator stated when they started their investigation, they initially thought the rubber bands were placed on Resident #1's wrists on Sunday 01/26/25 during second shift (3:00 PM to 11:00 PM); however, they were learning new details about when the rubber bands were actually placed on her wrists. He stated staff had been trained there was a zero tolerance for abuse and neglect that included the use of restraints. He indicated they were still in the process of conducting an investigation and had not yet been able to narrow it down to a specific individual or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 20	F 604		

how long the socks and rubber bands had been in place on Resident #1's hands.

The Administrator, DON and Regional Director of Operations were notified of Immediate Jeopardy on 01/29/25 at 6:00 PM.

The facility provided the following Credible Allegation of Immediate Jeopardy removal:

Address how corrective actions will be accomplished for those residents who have been affected by the deficient practice:
On 1/27/2025, Resident #1 was observed with a sock on each hand. A binding had been placed around each wrist to hold the socks in place. The facility failed to comply with its abuse and restraint policies and did not protect a resident with severe cognitive impairment from abuse through the use of restraints.

On 01/27/2025, a nurse aide removed the band and sock from one hand, and the licensed nurse removed the sock and band from resident #1's other hand for skin assessment. The injuries included redness and edema to the bilateral hands, blisters to top of the right hand, and a singular blister measuring, 17 centimeters x 20 centimeters x 0 centimeters to the palm of the right hand.

On 1/27/2025, resident #1 was assessed by the licensed nurse for any injury with redness, edema, and blistering to the right hand and edema and redness to the left hand. Pain assessment was completed by Director of Nursing (DON) using PAIN AIDE SCALE noting no abnormal respirations, no grimacing, guarding, or calling out (ongoing monitoring by licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 21	F 604		

nurse for pain or injury to continue). Resident receives 0.25 milliliters of morphine sulphate, oral solution 100 milligram/5 milliliters two times per day by mouth for pain. Bilateral hands were cleansed with wound cleanser, patted dry, applied xeroform dressing and loosely wrapped hands with kerlix.

On 1/27/2025, DON notified licensed nurses to continue pain assessments until the wound is healed.

On 1/27/2025, the physician was notified via phone of the incident by the Director of Nursing (DON) with new treatment orders received.

On 01/27/2025, the DON notified license nurses that resident #1 should be assessed (by licensed nurse) two times daily for 72 hours or as indicated for psychosocial harm. These assessments are completed by observing any deviations from normal routine, with none noted.

On 1/27/2025, the DON notified the responsible party of the incident.

On 01/27/2025, During the investigation, seven staff members who admitted to knowledge of the socks and/or rubber binding being on resident #1's hands and failing to report, were suspended pending investigation by the DON.

On 01/27/2025, 1:1 education was provided verbally by DON to staff who reported knowledge of socks on resident #1's hands regarding abuse policy, restraint policy and reporting of unusual behaviors to charge nurse.

On 01/27/2025, staff members caring for resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 22	F 604		

#1 were notified immediately by DON of care plan updates that reflect new skin alterations, unusual behaviors, and new interventions.

On 01/27/2025, Resident was assessed by physician who provided wound care and updated treatment orders.

On 01/27/2025, Provider gave a one-time additional dose of morphine prior to wound care.

On 01/27/2025, Resident was seen by wound care provider who provided treatment recommendations.

On 01/27/2025, Hospice was notified by licensed nurse after identification of concerns.

On 01/27/2025, DON notified State law enforcement and Adult Protective Services upon identification of concerns.

On 01/27/2025, immediately following identification of concerns, DON initiated an investigation. Investigation is ongoing by Administrator, DON, and Assistant Director of Nursing (ADON) and Unit Managers.

Law Enforcement continues to work with facility to identify alleged perpetrator or perpetrators.

All perpetrators who were aware of the use of socks and/or bindings on resident #1's hands, failed to report, and failed to remove the coverings and/or bindings are being terminated.

How will the facility identify other residents having the potential to be affected by the same deficient practice:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 23	F 604		

Residents that could not speak for themselves or those with cognitive impairments or those with behaviors have the potential to be affected by the deficient practice.

On 01/27/2025, all other residents were assessed by DON for use of any restrictive device/restraint with no other residents identified as having a restraint device. A hard copy of the assessment resides within the facility.

On 1/27/2025, DON completed an audit of all residents with a BIMS of 10 or greater. These residents were interviewed to determine if they were aware of any other incidents of using interventions that restrict movement. There were no new findings.

On 1/27/2025, DON and licensed nurses completed a skin audit for all residents with a BIMS of 9 or less to determine if they had any new skin areas that would indicate interventions being used that restrict movement. There were no new findings. Hard copies of the assessments reside within the facility.

On 1/27/2025, DON and Administrator completed interviews with all staff working over the last 5 days. These staff members were interviewed to determine if they were aware of any other incidents of using interventions that restrict movement. There were no new findings.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:
On 1/27/2025, the DON/Designee conducted all staff education in person and/or by telephone on the facility abuse and restraint-free policy to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 24	F 604		

include a "zero-tolerance" for any type of resident abuse. Education also included that all residents have the right to be free from harm, including unnecessary or excessive physical restraint, including applying socks and bindings to hands to hinder manifestations of behaviors or for resident safety. Newly hired or contracted staff will be educated prior to accepting an assignment and caring for residents. No staff will provide resident care without completing education. DON and ADON will be responsible to track education for all staff including new hires and contract staff. Administrator notified DON and ADON of these responsibilities on 1/27/2025.

On 01/27/2025, DON or designee educated all staff in person and/or by telephone to proper notification and appropriate intervention for unsafe or other unusual behaviors. Newly hired or contracted staff will be educated prior to accepting an assignment and caring for residents. No staff will provide resident care without completing education. DON and ADON will be responsible to track education for all staff including new hires and contract staff. Administrator notified DON and ADON of these responsibilities on 1/27/2025.

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur: On 1/27/2025, during an ad hoc QAPI meeting a root cause analysis was completed and the root cause was identified as the need for additional staff education on the use of restraints related to negative resident outcomes and resident abuse, as well as the failure to report unusual behavior. The decision was made to complete the following audits to maintain compliance with plan of correction:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 25	F 604		

DON/ADON/Unit managers shall audit 5 residents per week for 8 weeks via skin assessments to ensure that there is no indication of using interventions that restrict movement.

DON/designee will interview 5 staff members weekly (on alternating shifts) for 8 weeks to identify any concerns for use of restraints, improper behavior management techniques, or abuse.

Facility administrator will review findings of audits to identify patterns or trends and will present audits to QAPI for 2 months, adjusting the plan as needed to maintain compliance.

IJ removal date is 1/28/25.
The facility alleges compliance with this plan of correction as of 1/28/25.

A validation of the facility's corrective action plan for Immediate Jeopardy removal was completed on 01/31/25. Staff interviews revealed they had received inservice education on the facility's use of restraints policy which included the definition of physical restraints. Staff verbalized they were instructed that socks and rubber bands placed on a resident's hands should never be used as an intervention, was considered a restraint and to report any concerns to the Administrator immediately. Review of the attendance sign-in sheets revealed staff inservice education was completed on 01/27/25. Skin assessments were conducted on all cognitively impaired residents with no concerns identified. Alert and oriented residents were interviewed who all reported no concerns with restraints. An audit was conducted on 01/27/25 of all residents with no other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 604	Continued From page 26 restraints identified. All facility staff were interviewed on 01/27/25 and the employees who reported observing the socks and/or rubber bands on Resident #1 but did not remove them or inform anyone were suspended. Monitoring tools initiated on 01/27/25 through 01/31/25 were reviewed and completed as outlined in the facility's credible allegation with no concerns noted as identified. The Immediate Jeopardy removal date of 01/28/25 was validated.	F 604		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 27 §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, photographic evidence review and staff interviews, the facility failed to implement their abuse policy and procedure when nursing staff failed to identify and immediately report the use of a physical restraint for a resident with no medical symptoms along with no assessment for the need for a physical restraint. Staff reported observing socks placed on Resident #1's hands held in place by rubber bands wrapped around each wrist on 01/24/25 without immediately reporting to the Administrator. On 01/27/25 at approximately 12:00 AM, Resident #1 was observed with socks covering each hand that were secured with rubber bands wrapped around each wrist, effectively forming tourniquets (device often used in emergency situations to apply pressure to a limb or extremity to stop blood flow) on her wrists, but not in a controlled manner. Her hands appeared larger than normal through the socks and the rubber bands had to be cut in order to remove the socks from Resident #1's hands. Resident #1's right hand was edematous (abnormally swollen due to an accumulation of fluid in the bodies tissues) and bright red in appearance. There were several blisters on the top of the hand, a large fluid filled blister in the palm of the hand with some drainage and a red ligature (visible indentation left on the skin) mark around the right wrist. Resident #1 was evaluated by the Wound NP on 01/27/25 who noted the blister on the palm of Resident #1's right hand measured 17 centimeters (cm) by 20	F 607	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 28	F 607		

cm by 0 cm and ordered wound treatment to be applied daily. This was for 1 of 3 residents reviewed for abuse and restraints (Resident #1).

Findings included:

The facility's policy titled, Abuse and Neglect Protocol dated 06/13/21, revealed a policy statement that read in part, "Our residents have the right to be free from abuse, neglect, misappropriation, exploitation, corporal punishment, physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, and involuntary seclusion. All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management." The policy interpretation and implementation section revealed in part, that any staff member or person affiliated with this facility who witnessed or believed a resident had been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report the mistreatment or offense to the Administrator or Director of Nursing Services.

Resident #1 was admitted to the facility on 07/31/24 with diagnoses that included Alzheimer's disease, dementia and multiple sclerosis (a chronic disease that affects the nervous system).

A telephone interview was conducted with Nurse Aide (NA) #2 on 01/29/25 at 12:10 PM. NA #2 revealed she was employed by a staffing agency and verified she was assigned to provide Resident #1's care on 01/24/25, 01/25/25 and 01/26/25 during the hours of 7:00 AM to 3:00 PM. NA #2 stated she could not honestly recall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 29	F 607		

noticing if Resident #1 had socks or rubber bands on her hands or wrists on 01/24/25; however, she did notice the socks but no rubber bands on Resident #1's hands when she started her shifts on 01/25/25 and 01/26/25. She explained she left the socks on Resident #1's hands thinking they had been put there by the previous shift as an intervention to keep her from messing in her feces. NA #2 verified she did not ask anyone why Resident #1 had socks on her hands nor did she report it to anyone. She stated if she had known the socks should not have been on Resident #1's hands she would have told someone. NA #2 confirmed she had received inservice education on the facility's abuse and neglect policy and restraints and was instructed to immediately report any concerns to the Nurse Supervisor, DON or Administrator.

A telephone interview was conducted with NA #3 on 01/30/25 at 2:42 PM. NA #3 revealed she was employed by a staffing agency and verified she was assigned to provide Resident #1's care on 01/24/25 to 01/25/25 during the hours of 4:30 PM (she arrived late to work) to 7:00 AM and again on 01/26/25 during the hours of 3:00 PM to 11:00 PM. NA #3 recalled on 1/24/25 Resident #1 had an incontinence episode and NA #4 had assisted her with cleaning up Resident #1. NA #3 stated Resident #1 had socks on her hands that were removed and after care was provided, NA #4 placed new socks back on Resident #1's hands. At that point, NA #3 stated she went to assist Resident #1's roommate while NA #4 left the room. When NA #4 returned, she noticed he had rubber bands in his hands and he went around the privacy curtain to Resident #1. NA #3 stated she did not see NA #4 place the rubber bands around Resident #1's wrists but knew that he had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 30	F 607		

because the rubber bands were on Resident #1's wrists when she checked on her again later in the shift. NA #3 explained that when NA #4 put the socks on Resident #1's hands, she thought that was strange but NA #4 told her "that's just what they do" and she just assumed that was facility protocol to try and keep Resident #1 from messing in her feces. NA #3 confirmed she had received inservice training on abuse and restraints and was instructed to immediately report any concerns to administration. She stated she knew that the use of the socks and rubber bands on Resident #1's hands were considered a restraint and she didn't report it to anyone or question NA #4 further because he was sort of training her and seemed to know the residents well. NA #3 recalled when she started her shift on 01/26/25, Resident #1 still had the same socks on both her hands along with the rubber bands around her wrists that were put on 01/24/25 by NA #4. NA #3 could not recall how the socks looked when she started her shift on 01/26/25 or how Resident #1's hands and wrists appeared with the socks in place. NA #3 restated she knew for a fact that the socks and rubber bands were placed on Resident #1's hands by NA #4 on 01/24/25 and everyone who worked with Resident #1 since that date would have seen the socks and rubber bands but they all dropped the ball, herself included.

A telephone interview was conducted with NA #5 on 01/30/25 at 10:08 AM. NA #5 revealed she was employed by the facility and verified she worked on 01/25/25 during the hours of 7:00 AM to 3:00 PM on Resident #1's hall with NA #2. NA #5 recalled on 01/25/25 sometime right after lunch, NA #2 asked her to pull Resident #1 up in bed and when she did, she noticed Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 31	F 607		

had socks on each hand with one rubber band around each wrist that was holding the socks in place. NA #5 stated she did not notice anything unusual about how her hands looked with the socks on nor did she recall noticing any signs of swelling or redness on the visible skin. NA #5 expressed she did not question why Resident #1 had socks and rubber bands on her hands or report it to anyone. She stated she did not remove them and just assumed the socks were put on for a reason. NA #2 confirmed she had received inservice education on the facility's abuse and neglect policy and restraints and was instructed to immediately report any concerns to the Administrator.

A telephone interview was conducted with NA #6 on 01/30/25 at 11:32 AM. NA #6 revealed she was employed by a staffing agency and verified she was assigned to provide care to Resident #1 on 01/25/25 to 01/26/25 during the hours of 3:00 PM to 7:00 AM. NA #6 recalled when she started her shift on 01/25/25, Resident #1 had had socks on her hands with one (1) rubber band wrapped around each wrist holding the socks in place. She explained the rubber bands were slid over the wrist, not wrapped twice or tight, and described it like someone who would put a hair tie on their wrist loosely in case they wanted to pull their hair up. NA #6 stated usually the nurses were the only ones that had rubber bands and she just assumed the nurses had put the socks and rubber bands on Resident #1's hands and wrists for a particular reason and didn't ask anyone about it. NA #6 stated she assumed it was standard protocol because she was told that Resident #1 liked to dig in her bottom and play with/eat her fecal matter but realizes she should have told someone. She confirmed she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 32	F 607		

received inservice education on the facility's abuse and neglect policy and restraints and was instructed to immediately report any concerns to the Administrator. NA #6 restated she did not ask anyone why Resident #1 had socks and rubber bands on her hands and wrists on 01/25/25 nor did she report it to anyone.

A telephone interview was conducted with Nurse #3 on 01/30/25 at 3:04 PM. Nurse #3 revealed she was employed by the facility and verified she was assigned to provide care to Resident #1 on 01/25/25 and 01/26/25 during the hours of 7:00 AM to 7:00 PM. Nurse #3 stated on 01/26/25 she saw socks on both of Resident #1's hands but did not see any rubber bands. She stated she did not remove the socks from Resident #1's hands to observe the skin and explained the socks did not seem tight or swollen and there was no redness to her arms that she recalled. Nurse #3 stated she didn't question why the socks were placed on Resident #1's hands or report it to anyone because she knew that Resident #1 would play in and eat her feces and no one had brought any concerns regarding the socks to her attention. Nurse #3 confirmed she had received inservice education on the facility's abuse and neglect policy and restraints and was instructed to immediately report any concerns to the Administrator.

A telephone interview was conducted with Nurse Aide (NA) #1 on 01/29/25 at 1:21 PM. NA #1 revealed she was employed by the facility and verified she was assigned to provide Resident #1's care on Sunday 01/26/25 to Monday 01/27/25 during the hours of 11:00 PM to 7:00 AM. NA #1 recalled she was doing her initial incontinence rounds when she first went in to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 33	F 607		

check on Resident #1 around 12:00 AM. When she went into Resident #1's room and pulled back the covers she observed socks on both of Resident #1's hands that were being held in place by rubber bands. NA #1 stated she thought the rubber bands had been wrapped around Resident #1's wrists at least twice. She stated she could tell Resident #1's hands were swollen even with the socks on because her hands were pressed tightly against the socks and looked much bigger than they should have been. She explained Resident #1's hands were so large, she was not able to pull the socks or rubber bands off and had to cut them in order to remove them from Resident #1's hands. NA #1 stated she started with the right hand and once the sock was removed, she immediately noticed Resident #1's right hand was very swollen, the skin of her hand and wrist was bright red in appearance and there were red marks around her wrist where the rubber bands had been that started to bruise. Resident #1 also had several blisters on top of the right hand and a large blister covering the palm of her right hand that were leaking. NA #1 stated she immediately informed Nurse #1 and when Nurse #1 came to the room to assess Resident #1 she instructed NA #1 to cut the rubber bands and sock off the left hand. NA #1 recalled Resident #1's left hand was also swollen but less red in appearance with no blisters that she recalled and there were red marks around Resident #1's left wrist where the rubber bands had been. NA #1 was not sure who put the socks and rubber bands on Resident #1's hands but recalled staff mentioning in the past that Resident #1 messed with her feces; however, NA #1 had never witnessed Resident #1 display that type of behavior. NA #1 stated if Resident #1 had messed in her feces when she provided her care,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 34	F 607		

she would have just cleaned her up and would never have placed socks and/or rubber bands on her hands to deter the behavior because it would be considered a restraint.

A telephone interview was conducted with Nurse #1 on 01/29/25 at 1:48 PM. Nurse #1 revealed she was employed by the facility and verified she was assigned to provide Resident #1's care on Sunday 01/26/25 to Monday 01/27/25 during the hours of 11:00 PM to 7:00 AM. Nurse #1 recalled around 12:30 AM, Nurse Aide (NA) #1 came to let her know that Resident #1 was found with socks on her hands, rubber bands around her wrists and her hands were swollen. Nurse #1 stated she immediately went to assess Resident #1, NA #1 had already removed the sock and rubber bands off Resident #1's right hand and Nurse #1 stated she cut the sock and rubber bands off Resident #1's left hand. Nurse #1 recalled Resident #1's right hand was swollen, blistered and red and her left hand was swollen but not blistered. Nurse #1 notified the DON, called the on-call provider and while waiting for a return phone call from the on-call provider, she went ahead and provided treatment to Resident #1's right hand. Nurse #1 stated she looked through Resident #1's medical records and did not see any physician orders for socks to be placed on her hands and there was no intervention in her care plan either. Nurse #1 explained Resident #1 would play in her feces on occasion and she could only assume that was why someone had placed the socks and rubber bands on her hands; however, that was not an intervention the facility typically used. Nurse #1 stated no one had mentioned anything to her about the socks and rubber bands observed on Resident #1's hands until it was brought to her attention by NA #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 35	F 607		

During interviews on 01/29/25 at 3:42 PM and 01/30/25 at 9:40 AM, the Director of Nursing (DON) revealed she received a call from Nurse #1 on 01/27/25 around 1:15 AM informing her that she (Nurse #1) had observed socks on both of Resident #1's hands with rubber bands placed tightly around her wrists, both hands were swollen and the right hand had blisters. The DON stated she went to the facility, called the Administrator to inform him of the incident and then started an investigation. The DON stated socks placed on the hands and secured with rubber bands was considered a restraint and never an appropriate intervention to use on any resident. She explained facility hired and agency staff were informed during orientation that restraints were not something the facility used and they should immediately report to her or another member of Administration anytime restraints were observed in use.

During an interview on 01/30/25 at 4:44 PM, the Administrator recalled he woke up around 5:30 AM on 01/27/25 and noticed he had missed a call from the DON. He called the DON and she informed him of the incident involving Resident #1. When asked what he was told by the DON, he stated at that point she was describing the aftermath, basically the extent of Resident #1's injuries. The Administrator stated when they started their investigation, they initially thought the rubber bands were placed on Resident #1's wrists on 01/26/25 during second shift (3:00 PM to 11:00 PM); however, they were learning new details about when the rubber bands were actually placed on her wrists. He stated all staff had been trained that there was a zero tolerance for abuse and neglect that included the use of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 36	F 607		

restraints. He further stated it was his expectation for staff was to immediately report any suspicion of abuse which would include the use of restraints and explained if staff had questions or concerns about something unusual they had observed, then they were to report their concerns to him or the DON.

Review of the initial allegation report submitted by the facility to the Division of Health Service Regulation (DHSR) revealed an allegation type of resident abuse and noted Resident #1 was found with socks on her hands and a "soft binding" to hold the socks in place. The socks were immediately removed, all other facility residents were checked for similar interventions with no other concerns identified, staff education was initiated, and an investigation was underway. It was noted the facility was made aware of the incident on 01/27/25 at 1:15 AM, the initial report was submitted to DHSR via fax transmission on 01/27/25 at 2:43 AM and law enforcement was notified. The initial report was completed and signed by the Director of Nursing (DON).

Photographs taken of Resident #1's hands and wrists received via email correspondence dated 01/28/25 from the investigating Law Enforcement Officer were reviewed. In the first three photographs taken on 01/27/25, Resident #1's hand was covered in a gauze dressing and when the dressing was pulled back, the index finger was outside of the dressing and appeared swollen. The middle and ring fingers were bent inside the gauze dressing and you could partially visualize a raised fluid-filled blister starting at the base of the middle and ring fingers leading down the top of the hand. When the dressing was moved to visualize the wrist, the skin was red with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 37	F 607		

a blister and indentation mark on the inside of the wrist where the rubber bands had been. The remaining pictures taken on 01/28/25, revealed the skin on Resident #1's right hand was red from the wrist to the fingers and there was peeling skin on the top and palm. Her left hand and palm had minimal redness with no blisters and a red mark on the wrist.

Photographs of Resident #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 investigating Law Enforcement Officer were reviewed. There were three photographs in total. In the first photograph, both of Resident #1's hands were covered in grayish/tan gripper socks. The left hand was more prominent in the photograph and showed two rubber bands, approximately 1/8 of an inch in width, wrapped around the wrist twice and her hand above the wrist appeared 2 to 3 times its normal size in the sock. Her chin was resting on the right hand and the rubber bands were not visible but you could visualize how large her hand appeared in the sock. In the second photograph, the sock and rubber bands had been removed from the right hand and her palm was facing upward. There were red ligature marks on the lower part of the inside of her wrist. The skin on her wrist, hand and fingers were visibly swollen and bright red in appearance. There was a large, raised fluid-filled blister from the edge of the palm to the bend of her fingers that covered the width of the palm. The sock was still on her left hand and you could visualize a rubber band, approximately 1/8 of an inch in width, bound twice around her wrist. In the third photograph, was a left sided view of Resident #1's right hand that was facing upward and tilted slightly. There was a purple colored,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 38	F 607		

bruised area on the outer wrist along the red ligature mark. The skin from the wrist to the fingers were bright red and swollen 2 to 3 times its normal size, resembling a lobster claw. Just underneath the outer edge of the top of the hand were two raised fluid-filled blisters at the base of the hand and a fluid-filled blister at the bend of the ringer finger to the knuckle.

The Administrator was notified of Immediate Jeopardy on 01/29/25 at 6:00 PM. The facility provided the following corrective action plan:

Address how corrective actions will be accomplished for those residents who have been affected by the deficient practice:
On 1/27/2025, resident #1 was observed with a sock on both hands and rubber bindings had been placed around each wrist to hold the socks in place. This intervention caused swelling, redness, and a 17 x 20-centimeter blister on resident #1's right hand and redness and swelling on the left hand. The facility failed to comply with the abuse policy when 7 staff members were aware of the socks and/or rubber bindings and failed to report this form of restraint to facility administration. Because of the failure to report, the facility did not protect a resident with severe cognitive impairment from abuse through unnecessary restraints.

On 01/27/2025, seven staff members who admitted to knowledge of the socks and/or rubber bindings being on resident #1's hands and failing to report, were suspended pending investigation by the Director of Nursing (DON). Staff interviews attest that staff members began seeing the socks and/or rubber binding beginning on 1/19/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 39 On 01/27/2025, 1:1 education was provided verbally by DON to staff who reported knowledge of socks and/or rubber binding on resident #1's hands regarding abuse policy, restraint policy and the requirement to report suspected or actual abuse to the administrator or DON. On 01/27/2025, immediately following identification of concerns, DON initiated investigation. Investigation is ongoing by Administrator, DON, and Assistant Director of Nursing (ADON) and Unit Managers. All perpetrators who were aware of the use of socks and/or bindings on resident #1's hands, failed to report, and failed to remove the coverings and/or bindings are being terminated. How will the facility identify other residents having the potential to be affected by the same deficient practice: In an ad hoc Quality Assurance Process Improvement (QAPI) meeting on 1/27/25, the abuse and reporting policy was reviewed by the administrator to ensure no changes were needed. In attendance at this meeting were the DON, ADON, and Unit Managers. It was determined that no changes were needed. On 1/27/2025, the DON completed interviews with all residents having a Brief Interview for Mental Status (BIMS) of 10 or greater to ensure that they had not experienced any abuse that had not been reported. There were no new findings. Hard copies of these interviews reside in the facility. On 1/27/2025, the DON completed skin	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 40	F 607		

assessment with all residents having a BIMS of 9 or less to ensure there was no visual indication of abuse that had not been reported. There were no new findings. Hard copies of these interviews reside in the facility.

On 1/27/2025, DON and Administrator completed interviews with all staff working over the last 5 days. These staff members were interviewed to determine if they were aware of any other incidents of using interventions that restrict movement or abuse that had not been reported. There were no new findings. Hard copies of these interviews reside in the facility.

On 1/27/2025, the Administrator reviewed all grievances and facility reported incidents for the last 30 days to ensure that there were no examples of a failure to report incidents as required by facility abuse and reporting policy. There were no new findings.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:
On 1/27/2025, the DON/Designee conducted all staff education in person and/or by telephone on the facility abuse and restraint-free policy to include a "zero-tolerance" for any type of resident abuse or failure to report an incident or suspected incident of abuse. Education also included that all residents have the right to be free from harm, including unnecessary or excessive physical restraint, including applying socks and bindings to hands to hinder manifestations of behaviors or for resident safety. Education focused not only on the requirement to report any unusual devices that could restrict movement, but to have open communication with the Administrator, DON,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 41	F 607		

ADON, and Unit Managers about the resident population, asking questions or inquiring about any treatment or intervention that is new, uncommon, or suspected as possible abuse or a restraint. Newly hired or contracted staff will be educated prior to accepting an assignment and caring for residents. No staff will provide resident care without completing education. DON and ADON will be responsible for tracking education for all staff including new hires and contract staff. The administrator notified DON and ADON of these responsibilities on 1/27/2025.

On 01/27/2025, DON or designee educated all staff in person and/or by telephone to proper notification and appropriate intervention for unsafe or other unusual behaviors. Newly hired or contracted staff will be educated prior to accepting an assignment and caring for residents. No staff will provide resident care without completing education. DON and ADON will be responsible for tracking education for all staff including new hires and contract staff. The administrator notified DON and ADON of these responsibilities on 1/27/2025.

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur: On 1/27/2025, during an ad hoc QAPI meeting, a root cause analysis was completed, and the root cause was identified as the need for additional staff education on the requirement to report unusual behavior or concerns about any intervention that restricts movement when visualized, as well as the requirement to report any incident or suspected incident of abuse immediately to the Administrator or DON. The decision was made to complete the following audits to maintain compliance with the plan of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 42	F 607		

correction:

DON/designee will interview 5 staff members weekly (on alternating shifts) for 8 weeks to identify any concerns for use of restraints, improper behavior management techniques, or abuse to ensure that reporting has occurred if present.

DON/designee will review the 24-hour report (that includes Sbars) 5 x weekly for 8 weeks to identify any concerns for use of restraints, improper behavior management techniques, or abuse to ensure that reporting has occurred if present.

DON/designee will make a walking round 5 x weekly for 8 weeks to identify any concerns for use of restraints, improper behavior management techniques, or abuse to ensure that reporting has occurred if present.

The facility administrator will review findings of audits to identify patterns or trends and will present audits to QAPI for 2 months, adjusting the plan as needed to maintain compliance.

IJ removal date is 1/28/25.
The facility alleges compliance with this corrective action plan as of 1/28/25.

A validation of the facility's corrective action plan for Immediate Jeopardy removal was completed on 01/31/25. Staff interviews revealed they had received inservice education on the facility's abuse policy and use of restraints policy which included the definition of physical restraints. Staff verbalized they were instructed that socks and rubber bands placed on a resident's hands should never be used as an intervention, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 607	Continued From page 43 considered a restraint and to report any concerns to the Administrator immediately. Review of the attendance sign-in sheets revealed staff inservice education was completed on 01/27/25. Skin assessments were conducted on all cognitively impaired residents with no concerns identified. Alert and oriented residents were interviewed who all reported no concerns with restraints. An audit was conducted on 01/27/25 of all residents with no other restraints identified. All facility staff were interviewed on 01/27/25 and the employees who reported observing the socks and/or rubber bands on Resident #1 but did not remove them or inform anyone were suspended. Monitoring tools initiated on 01/27/25 through 01/31/25 were reviewed and completed as outlined in the facility's credible allegation with no concerns noted as identified. The Immediate Jeopardy removal date of 01/28/25 was validated.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		2/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 609	Continued From page 44 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, photographic evidence review and staff interviews, the facility failed to submit an initial report to the State Agency that included details that accurately reflected the cause and extent of a resident's injuries for 1 of 3 residents reviewed for abuse and restraints (Resident #1). Findings included: Review of the initial allegation report submitted by the facility to the Division of Health Service Regulation (DHSR) revealed an allegation type of resident abuse. The allegation details noted Resident #1 was found with socks on her hands and a soft binding to hold the socks in place. Resident #1 was sleeping and did not appear to have any mental anguish. The socks were immediately removed, all other facility residents were checked for similar interventions with no other concerns identified, staff education was initiated, and an investigation was underway. The details of physical or mental injury/harm revealed none was apparent at this time. It was noted the facility was made aware of the incident on	F 609	Criteria 1 The initial report was rectified upon submission of the investigation report submitted on 1/31/25, that detailed the injury including wound measurements, the findings of the investigation, and the corrective actions taken by the facility. Criteria 2 On 2/12/25, an audit was completed by the Administrator of all initial reports completed from 1/12/25 to 2/12/25 to determine trends or concerns related to accurate reporting on the initial report to Division of Health Service Regulation (DHSR). All other reports reflected accurate information that was known at the time of the report (prior to investigation). Criteria 3 On 2/12/25, the Administrator educated the Director of Nursing (DON) that all initial allegation reports must contain details of an incident as reported to them, regardless of whether they have had an opportunity to visualize the injury or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 609	Continued From page 45 01/27/25 at 1:15 AM, the initial report was submitted to DHSR via fax transmission on 01/27/25 at 2:43 AM and law enforcement was notified on 01/27/25 at 2:34 AM. The initial allegation report was completed and signed by the Director of Nursing (DON). Photographs of Resident #1's hands and wrists that were taken by Nurse Aide #1 on 01/27/25 and received via email correspondence on 01/29/25 from the investigating Law Enforcement Officer were reviewed. There were three photographs in total. In the first photograph, both of Resident #1's hands were covered in grayish/tan gripper socks. The left hand was more prominent in the photograph and showed two rubber bands, approximately 1/8 of an inch in width, wrapped around the wrist twice and her hand above the wrist appeared 2 to 3 times its normal size in the sock. Her chin was resting on the right hand and the rubber bands were not visible but you could visualize how large her hand appeared in the sock. In the second photograph, the sock and rubber bands had been removed from the right hand and her palm was facing upward. There were red ligature marks on the lower part of the inside of her wrist. The skin on her wrist, hand and fingers were visibly swollen and bright red in appearance. There was a large, raised fluid-filled blister from the edge of the palm to the bend of her fingers that covered the width of the palm. The sock was still on her left hand and you could visualize a rubber band, approximately 1/8 of an inch in width, bound twice around her wrist. In the third photograph, was a left sided view of Resident #1's right hand that was facing upward and tilted slightly. There was a purple colored, bruised area on the outer wrist along the red ligature mark. The skin from the	F 609	investigate the incident and that a clear picture of what allegedly occurred is conveyed to DHSR. Any updates or changes to the initial allegation can be corrected in the final investigation report. Criteria 4 The Administrator will audit all initial reports to DHSR monthly for 2 months to ensure that all initial allegation reports contain details of an incident as reported, regardless of whether they have been visualized or investigated and that a clear picture of what allegedly occurred is conveyed to DHSR. . The Administrator will review these audits in the monthly Quality Assurance Process Improvement (QAPI) meeting for 2 months or until substantial compliance is achieved. The audits will continue at the discretion of the QAPI committee. The Administrator is responsible for this plan of correction. Date of compliance is 2/13/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 609	Continued From page 46	F 609		

wrist to the fingers were bright red and swollen 2 to 3 times its normal size, resembling a lobster claw. Just underneath the outer edge of the top of the hand were two raised fluid-filled blisters at the base of the hand and a fluid-filled blister at the bend of the ringer finger to the knuckle.

During an interview on 01/29/25 at 3:42 PM, the DON revealed she received a call from Nurse #1 on 01/27/25 around 1:15 AM informing her that she (Nurse #1) had observed socks on both of Resident #1's hands with rubber bands placed tightly around her wrists, both hands were swollen and the right hand had blisters. The DON explained when she arrived at the facility at approximately 1:35 AM, Resident #1's hands were covered in a dressing after receiving treatment from Nurse #1 and she (Resident #1) didn't have the bandages removed until after the Law Enforcement officer arrived at the facility and they observed Resident #1's hands together. The DON stated she called the Administrator to inform him of the incident and then started an investigation which included submitting an initial report to the State Agency.

During an interview on 01/30/25 at 1:45 PM with the Regional Director of Operations and Administrator present, the DON was asked why the initial report indicated there was no apparent harm to Resident #1 and her only response was that when she completed and submitted the initial report, she hadn't yet observed Resident #1's hands or knew the extent of the actual injuries, just what was initially reported by Nurse #1. The DON expressed her main focus when completing the initial report was to get it submitted to the State Agency within two hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 609	Continued From page 47 During a joint interview on 01/30/25 at 1:45 PM with the Administrator and DON present, the Regional Director of Operations expressed the DON was trying to ensure the initial report was submitted on time and included the information initially reported to her by Nurse #1. The Regional Director of Operations stated the extent of the injuries was documented in their investigation and would be included in the 5-day investigation report.	F 609		