STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONVILLE	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted 11/20/24 through 11/22/24. Event ID #P0F911. The following intakes were investigated: NC00201192, NC00221817, and NC00223832. 2 of the 25 complaint allegations resulted in deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		12/4/24

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

Electronically Signed | 12/09/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff and Physician Assistant (PA) interviews and record review, the facility failed to notify the Physician or Physician Assistant (PA) about a newly identified pressure ulcer for 1 of 4 residents reviewed (Resident #3). The findings included: Resident #3 was admitted to the facility on 10/7/24 with diagnosis that included dementia and protein-calorie malnutrition. Resident #3 was discharged from the facility on 10/31/24. Review of a wound observation tool for Resident #3's sacrum dated 10/24/24 revealed that this was a facility acquired stage 2 pressure ulcer which was first identified on 10/18/24. The Wound observation tool was completed by Nurse	F 580	Corrective Action: Resident #3 (MR# 7176) was discharged from the facility on 10/31/24. Effective 11/25/24, Nurse #1 is no longer employed by facility. Like Residents: All residents have the potential to be affected. The Director of Nursing (DON) and/or licensed nurse (Registered Nurse [RN] and Licensed Practical Nurse [LPN]) will complete a Skin Assessment on all active Residents within the facility. Any new area identified will be assessed by a licensed nurse, notification made to the Physician	

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F 580	Continued From page 2 #1. A phone interview with Nurse #1 on 11/22/24 at 8:39 AM revealed that she was aware of a new wound for Resident #3 on the sacrum on 10/18/24. She further revealed that she did not document the occurrence or the treatment of the wound, nor did she inform the PA about the wound. She stated that she knew she should have told the PA and obtained an order for treatment. An interview with the PA on 11/22/24 at 11:31 AM revealed that if a skin issue that could result in a pressure ulcer was discovered the Nurse could start treatment but she would like to be notified as soon as possible. An interview with the Director of Nursing (DON) on 11/22/24 at 3:05 PM revealed that she recalled Resident #3. Nurse #1 told the DON that she did not notify the Physician or PA and get treatment orders. The DON stated that she was unsure why Nurse #1 did not complete the protocol that was in place for addressing new wounds. She stated that her expectation was that when a nurse discovered a new wound that they contact the Physician or PA and get a treatment order to start wound care. An interview with the Administrator on11/22/24 at 3:28 PM revealed that her expectation was that when a nurse discovered a new wound that she contacts the Physician or PA and obtains orders for treatment and documents that appropriately.	F 580	or Physician Assistant (PA), new treatment initiated as indicated, and Care plan & Kardex updated as indicated. This audit will be completed by 11/25/24. Systemic Changes: The Director of Nursing (DON) and/or licensed nurse will provide education to all licensed nurses (Registered Nurse [RN] and Licensed Practical Nurse [LPN]) on the facility policies, Change in Resident□s Condition or Status to ensure the Physician or Physician Assistant (PA) is notified of any newly identified pressure ulcer. Education will be completed by 12/3/24. *Any licensed nurse who has not completed education by 12/3/24 will not be allowed to provide direct resident care until education is completed. **The Executive Director (ED), Director of Nursing (DON), and/or Staff Development Coordinator (SDC) will provide education to all licensed nurses upon hire, annually, and as needed. Monitoring The Director of Nursing (DON) and/or licensed nurse will conduct audits (Audit #4 A Skin Integrity) on all skin assessments to ensure notification to the Physician or Physician Assistant (PA) for any newly identified pressure ulcers and to ensure treatment orders are obtained. Audits will be conducted five (5) times per week for four (4) weeks; then three (3) times per week for four (4) weeks; then	

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F 580	Continued From page 3	F 580	one (1) time a week for four (4) weeks. The Executive Director (ED) and/or Director of Nursing (DON) will provide education for any incidents of non-compliance. The Director of Nursing (DON) and/or licensed nurse will conduct audits (Audit #4 B Admission/Re-admission Skin Integrity) on new admission and re-admission skin assessments to ensure notification to the Physician or Physician Assistant (PA) for any identified wounds (pressure ulcers) and to ensure treatment orders are obtained. Results of the audits will be reported by the Director of Nursing to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. QAPI Committee Members include the following: the Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Director of Rehab, Director of Social Services, Director of Activities, Director of Human Resources, Business Office Manager, Director of Environmental Services, Director of Maintenance, Director of Health Information Management, Food and Nutrition Services Manager, and Consultant Pharmacist. Completion Date: 12/4/2024	

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Physician Assistant (PA) interviews, the facility failed to complete weekly skin assessments and comprehensive assessments including measurements of newly identified pressure ulcer and failed to obtain treatment orders which resulted in no treatment being completed for five days for 1 of 4 residents reviewed for pressure ulcers (Resident #3). The findings included: Resident #3 was admitted to the facility on 10/7/24 with diagnosis that included dementia and protein-calorie malnutrition. Resident #3 was discharged from the facility on 10/31/24. Review of the admission skin assessment dated 10/7/24 for Resident #3 revealed that there were no skin issues.	F 686	Corrective Action: Resident #3 (MR# 7176) was discharged from the facility on 10/31/24. Effective 11/25/24, Nurse #1 is no longer employed by facility. Like Residents: All residents have the potential to be affected. The Director of Nursing (DON) and/or licensed nurse (Registered Nurse [RN] and Licensed Practical Nurse [LPN]) will complete a Skin Assessment on all active Residents within the facility. Any new area identified will be assessed by a licensed nurse, notification made to the Physician or Physician Assistant (PA), new treatment initiated as indicated, and Care plan & Kardex updated as indicated. This	12/4/24

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F 686	Continued From page 5 Review of the admission minimum data set (MDS) dated 10/10/24 revealed that Resident #3 was severely cognitively impaired. Resident #3 was at risk for pressure ulcers. Resident #3 had no skin issues or injuries and had a pressure-reducing device on her bed. Review of the care plan dated 10/16/24 revealed that Resident #3 was at risk of developing a pressure ulcer due to a decrease in mobility. Goals included Resident #3, will be without the development of pressure areas through next review. Interventions included assist as needed to reposition/shift weight to relieve pressure. Clean and dry skin after each incontinent episode. Complete Braden scale risk assessment monthly and as needed. Encourage use of side rails to assist turning in bed. Float heels when in bed as needed/ordered. Minimize pressure over boney prominences. Notify nurses immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathing or daily care. Pressure reducing mattress. Weekly skin checks. No weekly skin assessments were documented as completed during Resident #3's stay at the facility. Review of a wound observation tool for Resident #3's sacrum dated 10/24/24 revealed this was a facility acquired stage 2 pressure ulcer which was first identified on 10/18/24. The wound observation tool was completed by Nurse #1. There was no documentation present on 10/18/24 to indicate the initial discovery of this pressure ulcer.	F 686	audit will be completed by 11/25/24. The Director of Nursing (DON) and/or licensed nurse (Registered Nurse [RN] and Licensed Practical Nurse [LPN]) will complete a Braden Scale Audit on all active Residents within the facility and update care plan & Kardex as indicated. This audit will be completed by 11/25/24. All residents identified with actual Pressure Ulcer(s) will be screened by therapy for appropriate interventions and plan of care updated as indicated. This audit will be completed by 11/25/24. Systemic Changes: The Director of Nursing (DON), Staff Development Coordinator (SDC), and/or licensed nurse will provide education to all licensed nurses (Registered Nurse [RN] and Licensed Practical Nurse [LPN]) on the facility policies: -Skin Integrity & Pressure Ulcer/Injury Prevention and Management - Documentation & Assessment of Wounds - Pressure Injury Prevention and Unavoidable Pressure Ulcer/Injury - Treatment Orders - Changes in Resident□s Condition or Status - Comprehensive Care Plans and Revisions -Wound care/treatment clean dressing change and complete skills evaluation The Director of Nursing (DON), Staff Development Coordinator (SDC), and/or licensed nurse will provide education to all certified nursing assistants (CNAs) on the	

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F 686	Continued From page 6 A physician's order dated 10/24/24 read, cleanse sacral wound with normal saline. Pat dry, apply calcium alginate (a material that absorbs excess moisture and promotes healing of wounds) inside wound border only, not touching edges. Cover wound with bordered foam gauze everyday. Turn resident every two hours every day shift for wound care. The order was discontinued on 10/31/24. Review of the treatment administration record (TAR) for the month of October 2024 revealed the treatment to Resident #3's sacrum was completed as ordered from 10/24/24 through 10/31/24. A phone interview with Nurse #1 on 11/22/24 at 8:39 AM revealed that she was aware of a new wound for Resident #3 on the sacrum on 10/18/24. She stated that she cleansed the wound with normal saline and applied a foam border dressing but did not stage the wound. She further revealed that she did not document the occurrence or the treatment of the wound. She stated that she knew she should have told the PA and obtained an order for treatment. An interview with the PA on 11/22/24 at 11:31 AM revealed that if a skin issue could result in a pressure ulcer was discovered the Nurse could start treatment. She stated that treatment orders being placed would have been nice but with Resident #3's poor nutrition and refusal to offload she felt this delay in treatment had not impacted the outcome of Resident #3's pressure ulcer. An interview with the Director of Nursing (DON) on 11/22/24 at 3:05 PM revealed that she recalled Resident #3. She spoke with Nurse #1 who	F 686	following policies: -Skin Integrity & Pressure Ulcer/Injury Prevention and Management - Changes in Resident□s Condition or Status Education will be completed by 12/3/24. *Any licensed nurse or certified nursing assistant who has not completed education by 12/3/24.will not be allowed to provide direct resident care until education is completed. **The Executive Director (ED), Director of Nursing (DON), and/or Staff Development Coordinator (SDC) will provide education to all licensed nurses upon hire, annually, and as needed. Monitoring: The Director of Nursing (DON) and/or licensed nurse will conduct audits (Audit #4 A Skin Integrity) on all skin assessments to ensure notification to the Physician or Physician Assistant (PA) for any newly identified pressure ulcers and to ensure treatment orders are obtained. Audits will be conducted five (5) times per week for four (4) weeks; then three (3) times per week for four (4) weeks; then one (1) time a week for four (4) weeks. The Executive Director (ED) and/or Director of Nursing (DON) will provide education for any incidents of non-compliance. The Director of Nursing (DON) and/or licensed nurse will conduct audits (Audit #4 B Admission/Re-admission Skin Integrity) on new admission and re-admission skin assessments to ensure notification to the Physician or Physician Assistant (PA) for any identified wounds	

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F 686	Continued From page 7 discovered Resident #3's sacral wound, and Nurse #1 told the DON that she discovered the wound on 10/18/24 and cleaned the wound with normal saline and applied a foam border dressing. The DON stated that she was unsure why Nurse #1 did not complete the protocol that was in place for addressing new wounds. She stated that her expectation was that when a nurse discovered a new wound that they would contact the Physician or PA and get a treatment order to start wound care. An interview with the Administrator on11/22/24 at 3:28 PM revealed that her expectation was that when a nurse discovered a new wound that she contact the Physician or PA and obtained orders for treatment and documented that appropriately.	F 686	(pressure ulcers) and to ensure treatment orders are obtained. Audits will be conducted five (5) times per week for four (4) weeks; then three (3) times per week for four (4) weeks; then one (1) time a week for four (4) weeks. The Executive Director (ED) and/or Director of Nursing (DON) will provide education for any incidents of non-compliance. The Director of Nursing (DON) and/or licensed nurse will conduct audits (Audit #4 C Monthly Braden Scale Audit) on Braden Scale documentation to ensure Braden Scales are completed Monthly. Audits will be completed weekly times twelve (12) weeks. The Executive Director (ED)and/or Director of Nursing (DON) will provide education for any incidents of non-compliance. The Director of Nursing (DON) and/or licensed nurse will conduct audits (Audit #4 D Admission/Re-admission Braden Scale) on Braden Scale documentation to ensure Braden Scales are completed weekly times four weeks after admission or re-admission. Audits will be conducted five (5) times per week for four (4) weeks; then three (3) times per week for four (4) weeks; then one (1) time a week for four (4) weeks. The Executive Director (ED) and/or Director of Nursing (DON) will provide education for any incidents of non-compliance. The Director of Nursing (DON) and/or licensed nurse will conduct audits (Audit #4 E Wound Observation Tool [WOT]) on Wound Observation Tool (WOT) to	

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F 686	Continued From page 8	F 686	ensure measurements are accurate and complete. Audits will be completed weekly times twelve (12) weeks. The Executive Director (ED) and/or Director of Nursing (DON) will provide education for any incidents of non-compliance. Results of the audits will be reported by the Director of Nursing to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. QAPI Committee Members include the following: the Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Director of Rehab,Director of Social Services, Director of Activities, Director of Human Resources, Business Office Manager, Director of Environmental Services, Director of Maintenance, Director of Health Information Management, Food and Nutrition Services Manager, and Consultant Pharmacist. Completion Date: 12/4/24	