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Form Approved OMB
No. 0938-0391

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47683 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 [DATE] 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 #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.

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.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47683 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 [DATE] 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 [DATE] for Resident #3 revealed that there were no skin issues. Review of the admission minimum data set (MDS) dated [DATE] 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. 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.