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	08/27/2025

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Life Care Center of Hendersonville	400 Thompson Street Hendersonville, NC 28792

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and staff interviews, the facility failed to ensure Registered Nurse (RN) coverage was provided for at least 8 consecutive hours per day for 5 of 6 days reviewed (Dates 02/01/25, 02/02/25, 02/09/25, 03/01/25, and 03/02/25). Findings included:Review of the daily nurse staffing sheets and associated time clock reports for the period 01/01/25 through 03/31/25 revealed the facility did not have the required RN coverage on the following dates: 02/01/25, 02/02/25, 02/09/25, 03/01/25, and 03/02/25.During an interview on 08/27/25 at 1:52 PM, the Central Supply Manager revealed she handled the Skilled Nursing staff schedules in January 2025 through March 2025. She stated there were times when no RN was scheduled daily from 8 to 12 hours, although she could not recall specific dates. The Central Supply Manager stated that when there was no RN scheduled for at least 8 consecutive hours, she notified the Former Administrator, and the Former Administrator handled the situation from that point.A telephone interview with the Former Administrator on 08/27/25 at 2:49 PM revealed she was employed at the facility in January 2025 through mid-to-late March 2025 and was aware that there were times when an RN was not scheduled for 8 consecutive hours on weekends. She stated she had a Minimum Data Set (MDS) Nurse who was an RN, work one weekend, and the Treatment Nurse, who was also an RN, work the opposite weekend to ensure there was RN coverage for 8 consecutive hours. The Administrator stated after she implemented having the MDS Nurse and Treatment Nurse working on alternating weekends she was not aware of any issues with not having an RN scheduled for 8 hours a day. She stated she could not recall the date when she implemented placing the 2 RNs on alternating weekends. During an interview with the Regional Director of Clinical Operations on 08/27/25 at 3:54 PM she acknowledged the facility did not have documentation of the required RN coverage on 02/01/25, 02/02/25, 02/09/25, 03/01/25, and 03/02/25. She stated she thought having the MDS Nurse and Treatment Nurse alternate weekends addressed the lack of RN coverage on weekends but there may have been times when there were call-outs or staff worked in a sister facility. The Regional Director of Clinical Operations stated with the change in nursing administration in May 2025 nurse staffing had improved and the facility had sufficient RN staff to ensure required RN coverage was met consistently.

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to ensure daily nurse staffing sheets accurately reflected the nursing staff who worked for 4 of 6 days reviewed (02/01/25, 02/02/25, 02/09/25, and 03/02/25). Findings included:Review of the facility's daily nurse staffing sheet revealed underneath the facility's name was a space to specify the date along with columns to specify the resident census, number of staff and hours worked for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) for each 12-hour shift, 7:00 AM to 7:00 PM (day shift) and 7:00 PM to 7:00 AM (night shift). a. The daily nurse staffing sheet dated 02/01/25 revealed on day shift there was 1 RN and 3 LPNs. The nursing staff time clock report for 02/01/25 revealed there were 3 LPNs and no RN.b. The daily nurse staffing sheet dated 02/02/25 revealed on day shift there was 1 RN and 3 LPNs. The nursing staff time clock report for 02/02/25 revealed there were 3 LPNs and no RN. c. The daily nurse staffing sheet dated 02/09/25 revealed on day shift there was 1 RN and 3 LPNs. The nursing staff time clock report for 02/02/25 revealed there were 3 LPNs and no RN. d. The daily nurse staffing sheet dated 03/02/25 revealed on day shift there was no RN and 3 LPNs. The nursing staff time clock report for 03/02/25 revealed there was an RN for 3 hours and 3 LPNs. An interview with the Assistant Director of Nursing (ADON) on 08/27/25 at 12:56 PM revealed since beginning employment in May 2025 she was responsible for completing daily nurse staffing sheets. She stated on weekends the nursing supervisor was responsible for updating the daily nurse staffing sheets to reflect call-outs and/or schedule changes. The weekend nursing supervisor was unavailable for interview during the survey. An interview with the Central Supply Manager on 08/27/25 at 1:52 PM revealed in February 2025 and March 2025 she was responsible for completing the daily nurse staffing sheets. She stated on Fridays she would complete and give the receptionist the daily nurse staffing sheets for Saturday, Sunday, and Monday and the receptionist would fill in the census and post the staffing each weekend day. She stated it was the responsibility of the nursing staff working the weekend to update the daily staffing sheets to reflect information such as call-outs and/or schedule changes. An interview with the Administrator on 08/27/25 at 4:18 PM revealed the ADON was responsible for posting and updating daily nurse staffing sheets throughout the week and the weekend nursing supervisor was responsible for posting and updating the sheets on weekends. She stated she expected the daily nurse staffing sheets to be updated as needed to reflect the correct number and hours of nursing staff that worked each shift.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with the Registered Dietitian (RD) and staff, the facility failed to follow the physician's diet order to provide double portions (Resident #10) and nutritional supplements (Resident #54) for 2 of 4 residents reviewed for nutrition (Resident #10 and Resident #54). Findings included:1. Resident #10 was admitted to the facility 04/28/25 with diagnoses including diabetes and malnutrition. Review of Resident #10's physician orders revealed an order dated 05/09/25 for a mechanical soft diet (a texture modified diet which restricts foods that are difficult to chew or swallow) and double portions. Resident #10's nutrition care plan initiated 05/16/25 revealed he had a nutritional problem related in part to malnutrition and diabetes. Interventions included having the Registered Dietitian (RD) evaluate and make diet changes as needed and providing and serving Resident #10's diet as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was severely cognitively impaired and received a mechanically altered diet. The MDS assessment further indicated he had a weight loss of 5% or more in the last month or weight loss of 10% or more in the last 6 months. An observation of Resident #10's lunch meal ticket on 08/24/25 at 11:59 AM revealed he was to receive a mechanically altered diet with double portions. An observation of Resident #10's meal tray at the same date and time revealed he received a large serving of mashed potatoes and cooked carrots and one small scoop of beef on his plate. An interview with Nurse Aide #1 on 08/24/25 at 11:59 AM revealed she set-up Resident #10's meal tray and did not notice he did not receive a double portion of beef. An observation of Resident #10's lunch meal with [NAME] #1 on 08/24/25 at 12:00 PM revealed he did not receive a double portion of beef on his meal tray. She stated double portions were considered to be 2 servings of a food item. [NAME] #1 stated she was working as a dietary aide on 08/24/25 and was responsible for checking meal trays for accuracy and she overlooked providing Resident #10 with a double portion of meat. An interview with the Dietary Manager on 08/27/25 at 9:16 AM revealed he expected residents to receive double portions as ordered. A telephone interview with the Registered Dietitian (RD) on 08/27/25 at 10:39 AM revealed she made a recommendation for Resident #10 to receive double portions as an intervention for weight loss. She stated she expected residents to receive double portions as ordered. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected residents to receive double portions as ordered. 2. Resident #54 was admitted to the facility 11/18/16 with a diagnosis of stroke. Resident #54's nutrition care plan last revised 04/10/25 revealed she was at risk for weight fluctuation related to her current health status and interventions included providing assistance with meals as needed and providing supplements as ordered. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 was severely cognitively impaired and did not have weight loss. Review of Resident #54's physician orders revealed an order dated 08/13/25 for a frozen nutritional supplement two times a day to promote weight stability.An observation of Resident #54's lunch meal ticket on 08/24/25 at 12:33 PM revealed she was to receive a 4-ounce frozen nutritional treat. An observation of Resident #54's meal tray at the same date and time revealed the frozen nutritional treat was not provided with her lunch meal. An interview with [NAME] #1 on 08/24/25 at 12:43 PM revealed the kitchen was out of frozen nutritional treats and she was unsure how long the facility had been out of the supplement. An additional observation of Resident #54's lunch meal ticket on 08/25/25 at 12:33 PM revealed she was to receive a 4-ounce frozen nutritional treat. An observation of Resident #54's meal tray at the same date and time revealed the frozen nutritional treat was not provided with her lunch meal. An interview with the Dietary Manager on 08/27/25 at 9:16 AM revealed dietary staff usually notified him if the facility ran out of nutritional supplements and he followed-up with the resident's nurse, but he had been out of town on 08/24/25 and 08/25/25. He stated in his absence, dietary staff should have notified the resident's assigned nurse that the frozen nutritional treat was unavailable. A follow-up interview with [NAME] #1 on 08/27/25 at 10:35 AM revealed she would usually notify the Dietary Manager when the facility was out of frozen nutritional treats, but he was unavailable and she did not notify Resident #54's nurse that the supplement was unavailable. A telephone interview with the Registered Dietitian (RD) on 08/27/25 at 10:39 AM revealed she expected residents to receive nutritional supplements as ordered. She stated if the facility ran out of ordered supplements, dietary staff should notify nursing staff so orders for an appropriate substitute could be obtained. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected residents to receive nutritional supplements as ordered and if they were unavailable, then nursing

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and staff interviews the facility failed to discard expired milk in 1 of 1 walk-in cooler; label and date a food item in 1 of 1 walk-in freezer; label and date open food items and store food off the floor in 1 of 1 dry storage room; maintain a clean and sanitary ice machine for 1 of 2 ice machines; and maintain a clean and sanitary refrigerator in 1 of 2 nourishment rooms (500/600 hall nourishment refrigerator). Findings included:1. An initial observation of the walk-in cooler on 08/24/25 at 9:22 AM revealed a 3/4 full box of 8-ounce cartons of 2% milk with a use-by date of 08/21/25. An interview with the Dietary Manager on 08/27/25 at 9:16 AM revealed the milk should have been used or discarded on or before the use-by date. He stated all dietary staff were responsible for checking for and removing expired food and beverage items. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected all food and beverages to be used or discarded on or before the use-by date. 2. An observation of the walk-in freezer on 08/24/25 at 9:28 AM revealed an unlabeled and undated bag of boneless chicken breasts sitting on a shelf. An interview with the Dietary Manager on 08/27/25 at 9:16 AM revealed he expected all food items to be labeled and dated. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected all food items to be labeled and dated. 3. An observation of the dry storage room on 08/24/25 at 9:32 AM revealed the following:a. an open and undated bag of powdered sugar sitting on a shelfb. an open and undated bag of graham crackers sitting on a shelfc. three boxes of nutritional supplement stored on the floorAn interview with the Dietary Manager on 08/27/25 at 9:16 AM revealed all opened food items should be labeled and dated by the staff member opening the items and no stock should be stored on the floor. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected all open food items to be labeled and dated, and no stock should be stored on the floor. 4. An observation of the ice machine in the dining room on 08/24/25 at 9:40 AM revealed a build-up of gray debris on the left vent. An interview with [NAME] #1 on 08/26/25 at 11:52 AM revealed maintenance was supposed to clean the ice machine. An interview with the Maintenance Director on 08/27/25 at 8:34 AM revealed a contract company de-limed and de-scaled the ice machine quarterly and he was responsible for ensuring the outside of the ice machine was clean. He stated he cleaned the ice machine if dietary staff made him aware of any areas that were visibly dirty, and he had not been informed of any concerns with the ice machine. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected the ice machine to be clean and free of debris. 5. An observation of the 500/600 hall nourishment room refrigerator on 08/24/25 at 11:17 AM revealed a large area of a dried white substance with cardboard stuck in the center on the middle shelf of the refrigerator. An interview with the Dietary Manager on 08/27/25 at 9:16 AM revealed he expected dietary staff to clean nourishment room refrigerators when they noticed they were dirty. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected the nourishment room refrigerators to be checked daily for cleanliness.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review and staff interviews, the facility failed to follow their infection control policy and procedure to implement Enhanced Barrier Precautions (EBP) for a resident with a diabetic foot ulcer (Resident #10) and failed to wear a protective gown during tracheostomy care (a surgical opening in the neck), and a dressing change for an endoscopic gastrostomy (feeding tube) for a resident on EBP (Resident #3). Additionally, the facility failed to follow their hand hygiene policy and procedure to remove gloves and perform hand hygiene when a soiled dressing was changed from around a feeding tube (Resident #3). The deficient practice occurred for 1 of 3 staff members observed for infection control practices (Treatment Nurse). The findings included: The facility’s EBP policy last revised on 4/22/25 revealed EBP was used as an additional MDRO (multidrug-resistant organism) mitigation strategy for any resident who met the criteria during high-contact resident care activities. Examples that met criteria for the use of EBP included chronic wounds and listed diabetic foot ulcers as a chronic wound. The policy’s definition of high-contact resident care activities that required glove and gown use included wound care of any skin opening that required a dressing. The policy included the facility had discretion in using EBP for residents who do not have a chronic wound. The policy indicated EBP should not be used for residents who are infected or colonized with an MDRO for which contact precautions were recommended in Appendix A of the Center for Disease Control and Prevention (CDC) guideline for isolation precautions. The CDC Appendix A guideline for a pressure ulcer with a minor or limited infection and if a dressing covered and contained drainage was to use standard precautions. 1. An observation of Resident #10’s wound care for a diabetic foot ulcer performed by the Treatment Nurse was conducted on 8/25/25 at 1:58 PM. There was no dressing in place at the time of the observation, and the wound did not have visible drainage. The Treatment Nurse used an alcohol-based hand sanitizer and put on a pair of gloves prior to care. The Treatment Nurse wiped the ulcer with gauze moistened with normal saline, applied a petroleum infused dressing, and covered the ulcer with a protective dressing. The Treatment Nurse did not wear a protective gown during Resident #10’s wound care for the diabetic ulcer on the right foot. During an interview on 8/25/25 at 3:44 PM, the Treatment Nurse revealed the old dressing was removed prior to the observation for assessment by the Wound Care Nurse Practitioner. The Treatment Nurse was asked if EBP were used for Resident #10 during care for the diabetic foot ulcer. The Treatment Nurse stated it was her understanding if the wound was 3 months old EBP were used and if not, she did not wear a protective gown during wound care for Resident #10’s diabetic foot ulcer. An interview was conducted with Director of Nursing (DON) in the presence of the Infection Preventionist on 8/27/25 at 8:30 AM and at 9:18 AM. It was explained the Treatment Nurse did not wear a protective gown while she provided wound care for Resident #10’s diabetic foot ulcer because EBP were not implemented. The DON confirmed EBP were not implemented for Resident #10 and only used for wounds that were present for 3 months or longer. The DON stated in the policy the facility had the discretion to use EBP for any resident who did not have a chronic wound. The DON stated she did not consider Resident #10’s diabetic ulcer as a chronic wound since it had not been present for 3 months. The DON stated the facility’s EBP policy included the CDC Appendix A and based on the guidance for pressure ulcers she had determined standard precautions should be used for Resident #10. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/25 at 3:56 PM, it was explained to the Administrator, EBP were not implemented for Resident #10 who had a diabetic foot ulcer, and during wound care the Treatment Nurse did not wear a protective gown when the wound was cleaned, and a new dressing applied. The Administrator stated based on the facility’s EBP policy the examples of chronic wounds included diabetic foot ulcers and should be implemented for Resident #10 and followed during wound care. 2. Review of the facility’s Enhanced Barrier policy last revised 04/22/25 read in part as follows: “Policy: The facility should use Enhanced Barrier Precautions (EBP) as an additional MDRO [multidrug-resistant organisms] mitigation [prevention] strategy for residents that meet the following criteria, during high contact resident care activities; EBP are indicated for residents with any of the following: Indwelling medical device examples includ[ing] feeding tubes and tracheostomies (a surgical opening in the neck that allows breathing). EBP should be used for any residents who meet the above criteria. Enhanced Barrier Precautions (EBP)-refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use include device care or use: feeding tube [and] tracheostomy/ventilator.” An observation of Resident #3’s door on 08/25/25 at 2:45 PM revealed signage indicating Resident #3 was on EBP and a shelf was hanging on the door containing gowns and gloves. A continuous observation of the Treatment Nurse on 08/25/25 from 2:47 PM through 2:58 PM revealed she entered Resident #3’s room, performed hand hygiene with alcohol-based hand rub (abhr), donned (put on) gloves, opened the tracheostomy care kit and added normal saline (salt water), removed the inner cannula (tube) and discarded it in the trash, removed her gloves and performed hand hygiene with abhr, donned sterile gloves, inserted a new inner cannula into Resident #3’s tracheostomy, removed the soiled gauze from the tracheostomy, removed her gloves, performed hand hygiene with abhr, donned clean gloves, cleaned around the tracheostomy with normal saline moistened gauze, removed her gloves, performed hand hygiene with abhr, donned clean gloves, applied a clean gauze to the tracheostomy, removed her gloves, and performed hand hygiene with abhr. The Treatment Nurse did not don a gown while providing tracheostomy care. An additional continuous observation of the Treatment Nurse on 08/25/25 at 2:59 PM through 3:02 PM revealed she performed hand hygiene with abhr, donned clean gloves, entered Resident #3’s room, removed the soiled gauze from Resident #3’s feeding tube, cleaned around the feeding tube with normal saline moistened gauze, dried the area around the feeding tube with gauze, applied clean gauze around the feeding tube, removed her gloves, performed hand hygiene with abhr, and exited Resident #3’s room. The Treatment Nurse did not don a gown while providing feeding tube care. An interview with the Treatment Nurse on 08/25/25 at 3:04 PM revealed she should have donned a gown when providing tracheostomy care and feeding tube care and she did not because it was an oversight. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 08/25/25 at 3:18 PM revealed she expected nursing staff to follow EBP when providing as indicated. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected staff to follow EBP when providing care as indicated. 3. Review of the facility’s hand hygiene policy last reviewed 07/07/25 read in part as follows: “Policy: The facility has adopted CDC [Centers for Disease Control] Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings for indications for hand hygiene that are generally consistent with the WHO [World Health Organization] 5 moments for hand hygiene. Definitions: Alcohol-based hand rub (ABHR) refers to a 60-95 percent ethanol [alcohol] or isopropyl alcohol-containing preparation base designed for application to the hands to reduce the number of viable micro-organisms. Hand hygiene refers to a general term that applies to hand washing, antiseptic handwash, and alcohol-based hand rub. Procedure: Associates perform hand hygiene (even if gloves are used) in the following situations: a. before and after contact with the resident; b. after contact with body fluids; c. after removing personal protective equipment (gloves, gown, eye protection, facemask) Introduction: An alcohol-based hand rub is appropriate for decontaminating the hands when moving from a contaminated body site to a clean body site during patient care and after contact with bodily fluids. 5 Moments for Hand Hygiene 1. before touching a patient 2. before a clean procedure 3. after body fluid exposure risk 4. after touching a patient 5. after touching patient surroundings.” (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continuous observation of the Treatment Nurse on 08/25/25 at 2:59 PM through 3:02 PM revealed she performed hand hygiene with abhr, donned clean gloves, entered Resident #3’s room, removed the soiled gauze containing a small amount of white drainage from Resident #3’s feeding tube, cleaned around the feeding tube with normal saline moistened gauze, dried the area around the feeding tube with gauze, applied clean gauze around the feeding tube, removed her gloves, performed hand hygiene with abhr, and exited Resident #3’s room. The Treatment Nurse did not remove her gloves and perform hand hygiene after removing the soiled gauze and before cleaning around the feeding tube. An interview with the Treatment Nurse on 08/25/25 at 3:04 PM revealed she would not remove her gloves and perform hand hygiene after removing soiled gauze and before cleaning around the feeding tube unless her gloves were visibly soiled. An interview with the Director of Nursing (DON) on 08/25/25 at 3:18 PM revealed she expected nursing staff to remove their gloves and perform hand hygiene after removing soiled gauze around a feeding tube. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected staff to remove their gloves and perform hand hygiene when moving from a dirty task to a clean task.