STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345400	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

(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 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a significant change assessment for 1 of 15 sampled residents who experienced a significant change (Resident #70) reviewed for activities of daily living and weight loss. Findings included: Resident #70 was admitted to the facility on 12/17/15. A review of the admission Minimum Data Set (MDS) dated 12/23/15 indicated Resident #70 required extensive assistance with eating and had a weight of 130 pounds. The 14 day MDS assessment dated 12/31/15 indicated Resident #70 was coded as supervision for eating and coded has having a weight of 121 pounds. Resident #70 had a weight loss of	F 274	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR EACH RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE AS LISTED IN THE 2567. 1. Since the resident was discharged from the facility we are unable to complete a significant change assessment correcting the error. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE WITH THE	2/25/16

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

Electronically Signed | 02/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345400	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

(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 274	Continued From page 1 greater than 5 percent in less than 2 weeks. On 02/04/16 at 11:43 an interview was conducted with the MDS Nurse who stated Resident #70 had a change in ADL with eating from admission MDS dated 12/23/15 to 14 day assessment MDS dated 12/31/15 and went from extensive assistance with eating to supervision. The MDS Nurse stated Resident #70 had a significant weight loss from admission MDS assessment to 14 day MDS assessment and went from 130 pounds to 121 pounds in 14 days. The MDS Nurse stated she missed coding a significant change MDS assessment for Resident #70. On 02/04/15 at 1:07 PM an interview with the Director of Nursing (DON) was conducted who stated her expectation was that the MDS Nurse would have coded Resident #70's MDS assessment to reflect a significant change had occurred. The DON stated her expectation was for the MDS nurse to have followed the MDS manual and guidelines for coding Resident #70's MDS assessment. On 02/04/15 at 1:13 PM an interview was conducted with the Administrator who stated her expectation was that the MDS Nurse would have coded Resident #70's MDS assessment per Resident Assessment Instrument manual and guidelines. The Administrator stated her expectations was that MDS Nurse would have coded Resident #70's MDS assessment to reflect a significant change had occurred.	F 274	FOLLOWING CORRECTIONS MADE TO RESOLVE THIS PARTICULAR SYSTEM PROBLEM: 1. An audit was completed on all completed MDS assessments since January 1, 2016. 2. Corrected significant change assessments will be completed by 2/25/2016 on any significant change assessments found to be missing during the audit. 3. All MDS staff was in-serviced on 2/15/2016 by Administrator and DON on regulations per the RAI manual regarding significant changes. 4. When completing an assessment, it will be compared to the most recent comprehensive and sub-sequent assessments for relative significant change areas. This will help us to recognize when a significant change occurs. 5. Continue to review and discuss any changes in condition from each department during the morning IDT meeting; Ex: Dietary □weight loss, Social Services □ cognitive changes/behaviors. This will be another check to recognize changes in the resident□s condition that need to be monitored for possible significant change assessments. 6. If a change in condition is noted, we will assess the change and complete the significant change assessment within 14 days if warranted. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345400	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

(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 274	Continued From page 2	F 274	THE DEFICIENT PRACTICE(S) WILL NOT OCCUR. 1. When completing an assessment, it will be compared to the most recent comprehensive and sub-sequent assessments for relative significant change areas. This will help us to recognize when a significant change occurs. 2. The DON/MR will conduct chart audits/MDS Assessments to review for accuracy. These audits will be completed weekly for 3 months and then quarterly thereafter. INDICATE HOW THE FACILITY PLANS TO MONITOR THE MEASURES TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTIONS ARE ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: 1. The DON/MR will conduct chart audits/MDS Assessments to review for accuracy. These audits will be completed weekly for 3 months and then quarterly thereafter. 2. These audits will be turned into the monthly QAPI meeting to evaluate improvements and assure compliance in accuracy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345400	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

(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 371	Continued From page 3	F 371		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to dispose of spoiled food and properly store foods together in refrigerator #1, label and date previously cooked food items in refrigerator #2, and label and date an item in the freezer. The findings included: During the initial tour with the Director of Food Services (DFS) beginning at 10:32 AM on 02/01/16, the following was revealed: 1. Refrigerator #1 had a rectangular shaped metal container with 8 oranges, celery with 3 wilted stalks and a brownish-black fuzzy substance on the exterior of the stalks, and a plastic, see through container with what the DFS stated was tartar sauce with no label or use by date. 2. Refrigerator #2 had a gallon sized storage bag with multiple cooked sausage patties and a second gallon sized storage bag with cooked scrambled eggs. Neither storage bag was labeled or dated. 3. The Freezer had a gallon sized storage bag	F 371	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR EACH RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE AS LISTED IN THE 2567. 1. All coolers/freezers were audited on 2/1/2016 to assure foods were labeled and stored properly to prevent cross contamination per regulation/facility policies. 2. Spoiled/molded food/produce and un-labeled items were discarded immediately while surveyor was present. 3. Dietary Staff present were verbally questioned and in-serviced immediately by the Dietary Manager regarding proper procedures for reporting and discarding spoiled produce/food upon delivery from vendors or if found in coolers/freezers. 4. Dietary Staff present were verbally questioned and in-serviced immediately by the Dietary Manager on the proper labeling/dating of foods prior to the cool	2/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345400	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

(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 371	Continued From page 4 with an opened bag of chocolate chip pieces inside. The storage bag was not labeled or dated. All contents in the metal container, and the storage bags with unlabeled and undated food items were disposed of in the kitchen waste receptacle immediately after these items were discovered during the initial tour. During an interview with Cook #1 on 02/03/16 at 3:57 PM, it was discovered that the sausage patties and scrambled eggs were leftovers from breakfast put in individual bags to be cooled by sitting them on ice before refrigeration. Cook #1 stated the sausage patties and scrambled eggs storage bags should have been labeled and dated but he had forgotten to do so. During an interview with DFS on 02/03/16 at 4:12 PM it was acknowledged that all food that had been cooked and would be used for another meal needed to be labeled with what was inside and dated. DFS also acknowledged that the celery should have been thrown out and the celery, oranges, and plastic container of tartar sauce should not have been stored together in the same container. DFS also indicated that the chocolate bits in the freezer should also have been labeled and dated. DFS stated re-education of the dietary staff had taken place since these issues had been discovered.	F 371	down process, and storage procedures to prevent cross-contamination. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE WITH THE FOLLOWING CORRECTIONS MADE TO RESOLVE THIS PARTICULAR SYSTEM PROBLEM: 1. All Dietary Staff was in-serviced on 2/10/2016 by the Dietary Manager regarding proper procedures for reporting and discarding spoiled produce/food upon delivery from vendors or if found in coolers/freezers. 2. All Dietary Staff was in-serviced on 2/10/2016 by the Dietary Manager on the proper labeling/dating of foods prior to the cool down process, and storage procedures to prevent cross-contamination. 3. All new hires will be properly trained on labeling/dating foods in the coolers/freezers, proper storage to prevent cross-contamination, cool-down process, and discarding spoiled/molded foods found upon delivery or in coolers/freezers. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE(S) WILL	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345400	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

(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 371	Continued From page 5	F 371	NOT OCCUR. 1. Facility “Food Storage” policy changed to include instruction on labeling food before initiating the cool down process, instructions on food separation to prevent cross-contamination, and procedures for reporting and discarding any foods found to be spoiled. 2. Manager/Assistant Manager/Cook will check fridge/freezers daily to assure items are labeled and stored correctly. INDICATE HOW THE FACILITY PLANS TO MONITOR THE MEASURES TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTIONS ARE ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: 1. Manager/Assistant Manager/Cook will check fridge/freezers daily to assure items are labeled and stored correctly. 2. These checks will be documented daily and turned into the Administrator monthly to be reviewed by QAPI to evaluate improvements and procedures to assure compliance.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345400	A. BUILDING: _____ B. WING _____	2/4/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on medical record reviews and staff interviews, the facility failed to maintain complete and accurate nurse's notes in the clinical record for 1 of 14 residents (Resident #74) reviewed.
The findings included:
Resident #74 was admitted to the facility on 08/31/15 with diagnoses which included a left sided fracture of the pelvis and left tibia (long bone in the lower leg), pain due to trauma, high blood pressure and anemia (low level of red blood cells resulting in weakness).

Review of hospital records on 02/02/16 at 2:33 PM indicated Resident #74 was discharged from the hospital to the facility on 08/31/15. Review of hospital records further indicated she was unable to tolerate surgery and she was too weak and injured to go home.

Medical record review on 02/02/16 at 2:53 PM indicated the 14 day assessment Minimum Data Set (MDS) was completed on 09/14/15. Resident #74 required extensive assistance with bed mobility, hygiene, transfers, eating, toileting and dressing and total assistance with bathing. Resident #74 was also noted to have short and long term memory problems, was incontinent of bowel and bladder, and had physical behavioral symptoms directed toward others including attempts to bite staff. Resident #74 was noted to be in frequent pain and was receiving both scheduled pain medications and as needed pain medications. Resident #74 also had an ulceration on her lower back upon admission.

Further medical record review revealed that a palliative care screening tool for Resident #74 was utilized. Resident #74 scored a 7 on the screening tool and scores above 5 indicated a consideration for a palliative care consult.

Review of physician's orders on 02/02/16 at 3:13 PM indicated an order was written for a palliative care consult on 09/08/15. A nurse practitioner met with the family of Resident #74 on 09/10/15 at the facility to discuss the progressive decline being seen in Resident #74. The focus of care was to be comfort measures with a limited trial of antibiotics and intravenous fluids if indicated but no feeding tubes. On 09/14/15 Resident #74 had a diet change from mechanical soft to a regular pureed diet and regular liquids.

On 02/02/16 at 4:20 PM nurse's notes from 08/31/15 to 09/15/15 were reviewed. Nurse's notes from

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345400	A. BUILDING: _____ B. WING _____	2/4/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	**193 ASHEVILLE HIGHWAY SYLVA, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	Continued From Page 1

09/14/15 timed at 7 AM - 7PM indicated the resident had uncontrolled pain, complained of anxiety, had an irregular heart rhythm, diminished breath sounds with crackles and a temperature of 99.6 degrees Fahrenheit. A review of the 24 report for 09/14/15 revealed on the 7AM to 7PM shift, Resident #74 also had " blood in urine, difficulty last pm with agitation - tried to bite and scratch." After the 09/14/15 7AM to 7PM note was written, the next nurse's note in the chart is on 09/15/15 at 6:30AM which stated "Resident pronounced @ 6:30 A this morning." It was also documented that the responsible party had been notified and that the funeral home had been made aware and the body was released to them.

During a staff interview with Nurse #1 on 02/02/16 at 4:39 PM, it was revealed that she was the nurse on shift on 09/14/15 from 7AM to 7PM. Nurse #1 remembered Resident #74 not doing well and being very anxious. Nurse #1 stated that Resident #74 was uncomfortable and was given several doses of an as needed medication for breakthrough pain relief.

During a staff interview with Director of Nursing (DON) on 02/03/16 at 11:04 AM, DON acknowledged that nurse's notes should have been made prior to resident's death between 7:00 PM on 09/14/15 and 6:30 AM 09/15/15. DON also acknowledged that the notification to the physician should have been documented but she knew he had been made aware of the resident's death.

During a staff interview with Nurse #2 on 02/03/16 at 11:05 AM, she indicated she was the staff on shift from 7:00 PM on 09/14/15 to 6:30 AM on 09/15/15. Nurse #2 acknowledged she remembered Resident #74 was on palliative care. Nurse #2 stated that Resident #74 had been able to take her meds and had not required any as needed medications and seemed to be resting comfortably. Nurse #2 stated that the Nursing Assistants (NA) had been checking on her every 2 hours until a NA came to tell her she thought Resident #74 had passed away. Nurse #2 stated she verified Resident #74 had passed away and began calling the family and the funeral home. Nurse #2 stated that the doctor was not called because he was in the building early that morning for a meeting and had been made aware of Resident #74's passing. Nurse #2 stated that she usually doesn't document on each shift unless the resident is Medicare or something significant happens. Nurse #2 stated she just forgot to go back and make a nurse's notes and acknowledged she should have documented what occurred with Resident #74 during her shift.