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 _____	C 06/30/2023

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/26/23 through 6/30/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LLA711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 6/25/2023 through 6/30/2023. The following intakes were investigated NC00196381, NC00196960, NC00201785. NC00196381 resulted in immediate jeopardy. 3 of 7 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at Tag F684 at a scope and severity J CFR 483.25 at Tag F689 at a scope and severity J The tags F684 and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 12/12/2023 and was removed on 6/28/2023. An extended survey was conducted.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:	F 554		7/10/23

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

Electronically Signed | 07/17/2023

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 _____	C 06/30/2023

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 554	Continued From page 1 Based on observations, record review, resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications for 1 of 1 sampled resident observed with medications at bedside (Resident #53). Findings included: Resident #53 was admitted to the facility on 04/19/21. Her diagnoses included heart failure, hypertension, and chronic obstructive pulmonary disease (difficulty breathing). The quarterly Minimum Data Set (MDS) dated 05/02/23 revealed Resident #53 had intact cognition and required limited to extensive staff assistance with most activities of daily living. Review of the medical record revealed no documentation in 2022 or 2023 that Resident #53 was assessed for self-administration of medications. Review of the physician's orders for Resident #53 revealed no order for self-administration of medications. During an observation and interview on 06/26/23 at 12:06 PM, Resident #53 was sitting up on the side of her bed with the overbed table pulled directly in front of her and placed on top of the overbed table was a medicine cup containing approximately 8 pills and two inhalers. Resident #53 picked up the medicine cup, put all the pills into her mouth and then took a drink of water to swallow the pills. Resident #53 was not observed to self-administer the inhalers. Resident #53 stated the pills were her morning medications that Nurse #1 had left for her to take. Resident #53	F 554	1. All medications were removed from resident # 53 bedside table and placed in the medication cart. 2. All nurses and med aides were educated by 7/10/2023 that they are never to leave medication at bedside without a doctor's order and proper care planning to assure the resident is safe to administer medications on their own. All new nurses and med-aides will be educated during orientation that they are never to leave medications at bedside without a doctor's order and proper care planning to assure the resident is safe to administer medications on their own. 3. There are no systemic changes needed as it the facilities policy that nursing staff is expected to stay at bedside with the resident to take all medications before leaving the room. 4. The Director of Nursing and/or designee will complete three med-pass medication administration competency assessments each week on different nurses and med aides. In addition to the weekly competencies, all nurses and med aides will be assessed for medication administration competency during their annual review. These competencies will be completed for six months, and if still finding education is needed, will extend another six months. If areas of improvement are needed the Director of Nursing will provide one-on-one education with the nurse or med aide.	

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 _____	C 06/30/2023

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 554	Continued From page 2 stated she had not requested to self-administer her medications and Nurse #1 usually waited as she took her medications before leaving the room but had not done so today. During an interview on 06/26/23 at 4:13 PM, Nurse #1 revealed when she administered Resident #53's morning medications, she watched Resident #53 lift the medicine cup to her lips, so she left the room thinking Resident #53 had put the pills in her mouth to swallow. Nurse #1 was unaware that Resident #53 had not taken her morning medications until 12:06 PM and stated she normally waited in the room with Resident #53 as she took her medications but did not this morning. Nurse #1 confirmed Resident #53 did not have an order to self-administer medications. During an interview on 06/28/23 at 3:45 PM, the Director of Nursing (DON) stated it was not facility procedure for nurses to leave residents oral medications or inhalers at bedside. The DON stated nurses were expected to wait at bedside for the resident to take their oral medications prior to leaving the room. In addition, nurses were to wait for the resident to use the inhaler as ordered and then place the inhaler back in the medication cart. The DON explained residents could get a physician's order to self-administer medications but had to be assessed first. She did not recall Resident #53 requesting or being assessed to self-administer her medications and confirmed Resident #53 did not have a physician's order to self-administer medications. During an interview on 06/30/23 at 12:17 PM, the Administrator stated nursing staff were expected to stay in the room to ensure residents took and	F 554	The Director of Nursing will turn the competencies into the Administrator each month to review as part of the monthly Quality Assurance Performance Imporovement meeting. The Director of Nursing and Administrator are responsible for assuring overall compliance. The completetion date for this POC was 7/10/2023.	

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 _____	C 06/30/2023

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 554	Continued From page 3 swallowed their oral medications. The Administrator further stated in order for a resident to self-administer medications, there needed to be a self-administration assessment completed and a physician's order.	F 554		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		7/10/23

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 _____	C 06/30/2023

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 655	Continued From page 4 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a baseline care plan within 48 hours of admission that addressed a resident's immediate needs for 1 of 4 sampled residents reviewed for baseline care plans (Resident #82). The findings included: Resident #82 was admitted to the facility on 05/22/23 with diagnoses including diabetes, pneumonia, and respiratory failure. The admission Minimum Data Set (MDS) assessment dated 05/28/23 revealed Resident #82 had moderate impairment in cognition. He required limited assistance with activities of daily living and used a walker and wheelchair for mobility. Further review revealed Resident #82 received insulin injections 7 of 7 days, anticoagulant (blood thinner) medication 7 of 7 days and antibiotic medication 5 of 7 days during the MDS 7-day look-back period. Review of Resident #82's medical record on	F 655	1. A comprehensive care plan was already completed for resident #82. Comprehensive care plans take the place of the baseline care plan. 2. The Director of Nursing audited all resident records on 6/28/2023 to ensure all residents baseline care plans were completed. The Director of Nursing in-serviced all nurses by 7/10/2023 on the process of completing the baseline care plan as part of the admission process. 3. No systemic changes are needed as it is already the facilities policy for the nurse to initiate & complete the baseline care plan upon admission. 4. The Director of Nursing and/or designee will review all new resident charts within 48 hours of admission to assure that the baseline care plan was completed as part of the admission	

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 _____	C 06/30/2023

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 655	Continued From page 5 06/28/23 at 2:27 PM revealed no evidence a baseline care plan was completed. During an interview on 06/28/23 at 4:00 PM, Nurse #3 revealed the admitting nurse was responsible for initiating baseline care plans. Nurse #3 could not recall if he was the admitting nurse when Resident #82 was admitted to the facility on 05/22/23. Nurse #3 confirmed no baseline care plan was initiated or completed for Resident #82 and stated it was likely just an oversight. During an interview on 06/29/23 at 10:23 AM, the Director of Nursing (DON) revealed the admitting nurse was responsible for initiating and completing baseline care plans. The DON verified Nurse #3 was the admitting nurse when Resident #82 was admitted to the facility. The DON stated a baseline care plan should have been completed for Resident #82 and might have been overlooked. During an interview on 06/30/23 at 12:17 PM, the Administrator explained baseline care plans should be completed by the admitting nurse as part of the admission process.	F 655	process. If a baseline care plan is found to be missing or incomplete, the Director of Nursing will re-educate the nurse and use disciplinary action if needed. The audit and any education completed due to non-compliance will be documented on the new audit tool and turned into the administrator monthly for the next six months and extended if warranted. The audit will be reviewed each month in the Qaulity Assurance Performance Improvement "QAPI" meeting. The Director of Nursing and Administrator are responsible for assuring overall compliance. POC Completed 7/10/2023.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and	F 658	1. All nursing staff were re-educated by	7/18/23

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 _____	C 06/30/2023

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 658	Continued From page 6 interviews with staff the facility failed to assure a nurse assessed a new skin tear and determined treatment for 1 of 4 residents reviewed for skin conditions (Resident #13). The findings included: Resident #13 was admitted to the facility on 04/19/18. Resident #13's diagnoses included Alzheimer's disease, dementia, and anxiety disorder. The quarterly Minimum Data Set (MDS) dated 05/22/23 assessed Resident #13 as having severely impaired cognition and extensive assistance was required for bed mobility and transfers and total assistance with toilet use. Review of the physician's standing orders for the treatment of skin tears read in part, "The nurse was responsible for documentation in the nurse notes, writing the order for treatment and filling out an incident report and notifying the Medical Doctor (MD) or Nurse Practitioner (NP)." Review of the medical records for Resident #13 revealed no documentation of an incident for a skin tear to the right forearm dated 06/24/23, 06/25/23, or 06/26/23. An observation made on 06/26/23 at 11:45 AM revealed a skin tear injury to the anterior middle right forearm of Resident #13. The skin tear was covered with two adhesive skin closures and measured approximately 3 to 4 centimeters in length. Resident #13 was unable to state the cause of the injury to the arm. A phone interview was conducted on 06/29/23 at	F 658	7/10/2023 about notifying the appropriate parties when an incident/accident occurs. These notifications should include the nurse, Director of Nursing "DON", provider, and responsible party. Incident/accident form was completed by DON for skin tear on resident # 13. 2. The Director of Nursing trained all nurses and Certified Nursing Assistants "CNA's" by 7/10/2023 on the process of notifying all parties of any incident/accident that occurs and documenting who they notified and the time on the incident form. These notifications should include the nurse, DON, provider, and responsible party. The nurse should then complete an incident form and document who was notified of the incident/accident and time of notification. 3. A new process has been developed that if a incident/accident occurs, the aides will notify the nurse immediately and then send a text notification to the Admin Nurse phone listing only the room # and injury. This notification will assure that admin staff is notified of any incidents that have occurred in case an incident form is not completed as required by the nurse and appropriate follow-up is initiated. All CNA's were in-serviced by 7/18/2023 on the new process. 4. The Director of Nursing or designee will check all incident & accident reports and	

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 _____	C 06/30/2023

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 658	Continued From page 7 10:14 AM with Nurse Aide (NA) #2. NA #2 stated on 06/24/23 when assisting Resident #13 to bed, the resident started swinging her arm towards her trying to hit her. NA #2 stated she saw it coming and moved back out of the way and when she did Resident #13's body tilted when she was swinging her arms and Resident #13's left hand hit her right forearm causing the skin to peel back. NA #2 revealed she did not see the nurse and placed adhesive skin closures on the resident's right forearm. NA #2 revealed another resident's call light was sounding and she went to answer it and forgot to tell the nurse about the skin tear. NA #2 revealed she typically informed the nurse when a resident obtained a skin tear during her care and apologized stating she got busy and forgot. An interview was conducted on 06/29/23 at 10:36 AM with Nurse #2. Nurse #2 confirmed she the assigned nurse for Resident #13 on 06/24/23 at the time the skin tear injury occurred. Nurse #2 stated she was not notified Resident #13 obtained a skin tear during care provided by NA #2 on 06/24/23. During an interview on 06/28/23 at 12:48 PM the Director of Nursing (DON) revealed she could not find an incident report to explain how the skin tear injury occurred to Resident #13's right forearm. The DON revealed typically an incident report was completed and both her and the Wound Care Nurse were informed when a resident obtained a skin tear injury. The DON confirmed neither her nor the Wound Care Nurse were notified of the skin tear injury for Resident #13. During a follow-up interview on 06/28/23 at 3:17 PM the DON revealed Resident #13's right	F 658	admin cell phone text messages from the previous day each morning and sign off that all notifications have been made on incident & accidents. If a nurse or CNA fails to notify all required parties of an incident or accident, the Director of Nursing will re-educate the nurse/CNA and use disciplinary action if needed. The Director of Nursing will document on the audit form that all incident & accident reports have been checked from the previous day and any education that had to be completed due to non-compliance of proper notifications. The audit will be completed for a minimum of one year. The process of checking incident reports daily will be indefinite. The audit will be turned into the Administrator monthly to review in the monthly Quality Assurance Performance Improvement "QAPI" meeting to ensure overall compliance. The Director of Nursing and Administrator are responsible for assuring overall compliance. POC Completed 7/18/2023.	

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 _____	C 06/30/2023

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 658	Continued From page 8 forearm skin tear injury occurred on 06/24/23 during care when NA #2 was assisting the resident into bed. The DON revealed NA #2 could not find the nurse and placed the adhesive skin closures on the arm. The DON stated NA #2 forgot to inform the nurse about the incident.	F 658		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of surveillance video, and interviews with staff, Nurse Practitioner (NP) and Medical Director (MD), the facility failed to assess Resident #287 immediately after a fall from the contracted transportation van. On 12/12/22 Resident #287 was rolled out of the back of the contracted transportation van in her wheelchair and fell to the ground landing on her left side and hitting the back of her head. The Contracted Transporter lifted Resident #287 back into her wheelchair and wheeled her into the facility without being assessed by a licensed professional. The Resident complained of mid back pain at 7 out of 10 (10 being the worst pain) and bruising was noted on her right forearm. Resident #287 was sent to the emergency department for evaluation and diagnosed with a compression fracture of the L1 vertebrae. There	F 684	1. All staff and agency staff were in-serviced on 6/26/2023 about what to do if they witness a fall. All in-house transportation staff were in-serviced on 6/27/2023 on signage posted in the van on the proper way to load/unload residents and steps to take if an incident or accident happens in the van. 2. All staff and agency staff were in-serviced on 6/26/2023 by the Administrator and Staff Development Coordinator on what to do if they witness a resident fall. The orientation process was reviewed,	6/30/23

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 _____	C 06/30/2023

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 684	Continued From page 9 is the high likelihood of further injury when a resident is moved after a fall before being assessed by a licensed professional. This deficient practice occurred for 1 of 3 residents review for accidents (Resident #287). Immediate Jeopardy began on 12/12/22 when the Contracted Transporter lifted Resident #287 from the ground back into her wheelchair even after being instructed by a staff member not to move the Resident. Immediate Jeopardy was removed on 6/28/23 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. Findings Included: Resident #287 was admitted to the facility on 12/08/22 with diagnoses that included end stage renal disease with dialysis dependency and diabetes mellitus type 2. The admission Minimum Data Set (MDS) dated 12/14/22 revealed Resident #287 was cognitively intact and required extensive assistance with transfers and was receiving dialysis during the assessment lookback period. A review of a transportation contractor document titled North Carolina Department of Transportation (NCDOT) integrated Mobility Division: Minimum Training Standards dated January 2022 read in part training must be conducted with new hires and annually thereafter	F 684	and reporting accidents and proper assessing was already part of the orientation process and will continue as part of the initial facility education and orientation. All in-house transportation staff was in-serviced on 6/27/2023 by the Transportation Director. This in-service included reviewing the pictures posted in facility van showing the proper way to load/unload residents and re-reviewed the signage posted in the van on the steps to take if an incident/accident happens in the van. This will be trained for all in-house drivers at least yearly. 3. Contract cancelled on March 20, 2023, for the outside transportation company. We only use in-house transportation except for ambulance services. There are no systemic changes needed as it is the facilities policy that a nurse is to assess before a resident is moved after a fall. 4. The Director of Nursing "DON" will review all incident and accident reports to assure proper assessment has been completed. She will then document this on the audit tool and turn it into the Administrator each month for six months to review in the monthly Quality Assurance Performance Improvement "QAPI" meeting to assure compliance. The DON and Administrator are responsible for ensuring overall	

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 _____	C 06/30/2023

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 684	Continued From page 10 as refreshers training with re-certification. Training topics included wheelchair/mobility device training, securement, emergency procedures for medical emergencies, accident or incident reporting procedures, and lift/ramp inspection and operation. The contracted van driver completed these trainings upon hiring. Review of an incident report dated 12/12/22 at 11:36 AM completed by Nurse #3 read in part, Nurse #3 was called to the front of the building and informed that a resident had fallen from her wheelchair onto the lift. Resident #287 stated she had fallen while being escorted from the transport van by the Contracted Transporter. Resident #287 had a small bump to the back of her head. She also had some bruising to her right forearm and complained of mid back pain 7 out of 10. A review of the facility's security video with the Administrator occurred on 6/27/23 at 2:30 PM. The video footage did not contain sound and was partially obscured as Resident #287's wheelchair was seen tumbling from the back of the contracted transportation van without Resident #287 in it. The van's opened back doors partially obstructed the view of the accident and Resident #287 was unable to be viewed falling out of the wheelchair and hitting the grounded gate lift. The video footage showed Resident #287 lying on the grounded lift gate of the van with the Contracted Transporter soon after arriving to Resident #287. Nurse Aide (NA) #3 comes into to view and was seen speaking with the Contracted Transporter and then entering the facility as the Contracted Transporter picked up Resident #287 underneath the arms and placed her into the wheelchair. The Contracted Transporter pushed Resident #287	F 684	compliance. The POC was completed on 6/30/2023.	

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 _____	C 06/30/2023

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 684	Continued From page 11	F 684		

into the facility. Resident #287 was seen entering the facility without any visible blood and pointing at the back of her head and did not appear to be in distress.

A review of the statement signed by the Contracted Transporter dated 12/12/22 read in part, "I was unloading Resident #287. While unloading the lift was unfolded without my knowledge, I pushed her out and she fell to the ground". I immediately got down to see if she was okay. Never lost consciousness. She stated she was okay. Got her back in the chair. Again, asked if she was okay, she stated she was still okay. I parked the van and came straight inside. Happened around 11:30. Struck the right side of body".

The Contracted Transporter was unable to be interviewed due to no phone contact information.

Resident #287 was discharged from the facility 1/7/23 and was unable to be interviewed.

The facility's Transportation Supervisor was interviewed on 6/30/23 at 9:10 AM. The Transportation Supervisor reported contracted transporters were not trained or educated by her or the facility. Contracted transporters were trained and certified by the company they worked for, and the Contracted Transporter received his training from the NCDOT as required for hiring.

The Contracted Transportation Supervisor was interviewed via telephone on 6/27/23 at 3:30 PM. She confirmed the Contracted Transporter had received his NCDOT training before he was allowed to transport residents. The Contracted Transportation Supervisor stated she could not

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 _____	C 06/30/2023

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 684	Continued From page 12	F 684		

give any other information.

An interview was conducted with NA #3 on 6/26/23 at 1:53 PM. She stated she observed Resident #287 lying on her left side in the fetal position on the ground behind the van as she entered the parking area returning from her break. The resident's wheelchair was located behind and to the side of lift gate. NA #3 explained she spoke to the Contracted Transporter and instructed him to not move Resident #287 as she was going to find assistance from inside the facility. She observed the Contracted Transporter in the process of moving the resident from the ground but did not observe the Contracted Transporter placing the resident back into the wheelchair.

Nurse #3 was interview on 6/27/23 at 1:40 PM and stated he was paged overhead by the receptionist to go to the front of the building because a resident had fallen from a transportation van. The Resident was in the front lobby of the facility sitting in her wheelchair when he arrived, and the Contracted Transporter said he was not paying attention to the resident, and she fell out of the van. Nurse #3 stated he assessed Resident #287 in her room who was alert and talking with complaints of intermittent pain in her back and indicated she hit the back of her head.

A review of the Nurse Practitioner (NP) assessment note dated 12/12/22 read in part Resident #287 was returning to the facility from dialysis. "The driver of the transit van apparently dropped the patient (Resident #287) from the lift. He (van driver) picked the patient up and put her into the wheelchair to bring her back into the facility. The patient is complaining of acute low

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 _____	C 06/30/2023

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 684	Continued From page 13	F 684		

back pain. Pain is increased with any movement of her legs". She did hit the back of her head and has a small abrasion or contusion with complaints of a headache. Resident to be transferred to the ED for evaluation.

An interview with the NP was conducted on 6/28/23 at 9:33 AM. The NP stated had assessed the resident when the resident returned to her unit after the fall from the contracted transportation van. The resident appeared uncomfortable and had told her she had been dropped and the Contracted Transporter picked her up and put her back into the wheelchair. The NP stated that Resident #287 could have had more injury because the Contracted Transporter had moved the resident without being assessed by a licensed staff first.

A review of Emergency Department (ED) notes dated 12/12/22 revealed the patient 's chief complaint was a fall. The patient reported sharp shooting pain back of her head and lumbar spine, non-radiating, constant, and worse with motion. The patient denied any neck pain. The ED diagnostic imaging found a 50% compression of L1 (lumbar) vertebral body. The ED plan of care recommended supportive care measures with a primary care physician follow-up. Resident #287 was provided one tablet of oxycodone 325 MG (pain medication) while in the ED. She discharged from the ED on 12/12/22 and sent back to the facility.

The Medical Director (MD) was interviewed on 6/30/23 at 10:10 AM. He stated that in general moving a resident without a licensed professional assessing them could result in further injury.

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 _____	C 06/30/2023

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 684	Continued From page 14	F 684		

The Administrator was interviewed on 6/26/23 at 1:53 PM. She reported she was notified immediately on 12/12/22 when Resident #287 had fallen from a contracted transportation van in the parking lot and went to the front entrance of the building. The Contracted Transporter had picked up the resident and placed her into the wheelchair before licensed staff could assess her. The resident's assigned nurse, Nurse #3, was called to the front to assess and take Resident # 287 to her room. The NP was in the facility, assessed the resident and sent the resident to the ED for evaluation. Resident #287 had a fractured L1 vertebrae from the accident. The Administrator stated the Contracted Transporter was interviewed and the security video footage was reviewed to see the cause of the accident. The Administrator stated the facility initiated an investigation immediately and was able to get a written statement and an interview from the Contracted Transporter before he left. The Contracted Transporter stated he pushed Resident #287 out of the van, and she fell to the ground. The Contracted Transporter immediately got down from the van to check if she was ok. The Contracted Transporter reported Resident #287 reported to him she was ok, and he placed her back into her wheelchair and he pushed her inside the building.

The Administrator was notified of Immediate Jeopardy on 6/26/23 at 6:10 PM

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

1. The facility immediately conducted an action plan to address contract transportation services

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 _____	C 06/30/2023

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 684	Continued From page 15	F 684		

with post-accident policies to include assessment. Included in this action plan was but not limited to:

o On 12/12/2022 - 12/15/2022 we worked with the contracted transportation company to ensure training of all contract drivers that provide services to Skyland Care Center including the individual involved in the accident. I spoke directly with the supervisor about the driver moving the resident before our nurse came to assess. She informed me that she was doing an internal investigation, and this was against their companies' procedures and the driver should have immediately called 911 after the incident. She informed me that the driver was in-serviced on this procedure and if allowed to continue employment, he would be in-serviced again. I also requested training with contracted drivers to notify the facilities front desk staff prior to assisting residents from vehicles to ensure the transfer is completed safely. The driver was not allowed to drive any facility residents if the contracted company allowed his employment going forward.

o On 12/15/2022 the administrator in-serviced all front reception employees to locate a CNA/Nurse when transit notified them, they were in the parking lot. They were to go to the transit vehicle and stand beside the lift to assure the residents are unloaded safely. As of March 20, 2023, we no longer use a contracted agency for transportation and all transportation is performed in house unless the resident needs stretcher service and then they are transported per EMS.

2. The facility terminated its transportation contract in March 2023 and no longer has an outside transport company they currently use.

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 _____	C 06/30/2023

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 684	Continued From page 16	F 684		

3. On 6/26/2023 the Administrator and Staff Development RN conducted an in-service for all employees on what to do if they witness a resident fall. Staff will not be allowed to complete a shift before completion of the training. In addition, the orientation process was reviewed, and reporting accidents and proper assessing was already part of the orientation process and will continue as part of initial facility education and orientation.

The education included:

a. Call for a nurse to evaluate for possible injuries (DO NOT MOVE THE RESIDENT UNTIL ASSESSED BY A NURSE).
b. Obtain vital signs as soon as safe to do so.
c. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately.
d. Notify residents attending physician and family in an appropriate time frame.
e. Report violations of these procedures to the Administrator.

4. Training for all in-house transportation staff was started on 6/27/2023 by the Transportation Director. Transportation staff will not be allowed to drive the van until they have completed the in-service. The in-service included reviewing pictures posted in facility van showing the proper way to load/unload residents and re-reviewed the signage posted in the van citing the steps to take if incident/accident happens in route. These steps include 1. Call 911, 2. DO NOT MOVE RESIDENT UNTIL ASSESSED BY EMERGENCY OFFICIALS, 3. Call Administrator, 4. Call facility

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 _____	C 06/30/2023

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 684	Continued From page 17 to send nurse to the scene, and 5. Wait for further instructions. This was recently in-serviced in our annual October 2022 in-service. 5. The Administrator is responsible for all issues related to immediate jeopardy removal. Alleged IJ removal date: 6/28/23 On 6/30/23 the facility's plan for Immediate Jeopardy removal effective 6/28/23 was validated by the following: Documentation and interviews with staff. Review of the in-service sign in sheets revealed all facility staff received education on what to do if they witness a resident fall. Staff who worked in each department and on all shifts were interviewed. Interviewed facility staff reported they should not move a resident who had fallen before the resident could be assessed by a nurse. Interviewed licensed facility staff reported after the resident had been assessed by a nurse, vitals would be taken, first aid or medical treatment would be administered if appropriate, and the attending physician and family would be notified as soon as possible. Interviewed transportation staff stated if a resident fell during transport, 911 would be called immediately, the resident would not be moved until assessed by emergency officials, the Administrator and facility would be called. The transportation staff stated instructions for actions to take if an accident or incident occurs were posted in the van. The transportation guide instructions were observed accessible in the vans along with posted	F 684		

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 _____	C 06/30/2023

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 684	Continued From page 18 photographs demonstrating residents facing out of the van when unloading. The facility no longer uses any contracted van services.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, video surveillance review, and staff and Nurse Practitioner interviews the facility contracted van driver failed to ensure the lift gate was in the elevated position before unloading a resident from the back of a facility contracted van. On 12/12/22 Resident #287 was rolled out of the back of the contracted transportation van in her wheelchair and fell to the ground landing on her left side and hitting the back of her head. The Resident complained of mid back pain at 7 out of 10 (10 being the worst pain) and bruising was noted on her right forearm. Resident #287 was sent to the emergency department for evaluation and diagnosed with a compression fracture of the L1 vertebrae. This occurred for 1 of 3 residents sampled for accidents (Resident #287). Immediate Jeopardy began on 12/12/22 when Resident #287 was rolled out of the back of the contracted transportation van in her wheelchair and fell to the ground. Immediate Jeopardy was	F 689	1. All staff and agency staff were in-serviced on 6/26/2023 about what to do if they witness a fall. All in-house transportation staff were in-serviced on 6/27/2023 on the facility lift and safety procedures in accordance with the manufacturers specifications and demonstrated competency. 2. All staff and agency staff were in-serviced on 6/26/2023 by the Administrator and Staff Development Coordinator on what to do if they witness a resident fall. The orientation process was reviewed, and reporting accidents and proper assessing was already part of the orientation process and will continue as part of the initial facility education and orientation.	6/30/23

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 _____	C 06/30/2023

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 689	Continued From page 19 removed as of 6/28/23 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: Resident #287 was admitted to the facility on 12/08/22 with diagnoses that included end stage renal disease with dialysis dependency and diabetes mellitus type 2. The admission Minimum Data Set (MDS) dated 12/14/22 revealed Resident #287 was cognitively intact and required extensive assistance with transfers and was receiving dialysis during the assessment lookback period. She used a wheelchair and a walker for mobility. Review of a facility document titled "Transportation Service Agreement" for the transit contractor dated July 1, 2022, through June 30, 2023, read in part that the contractor agrees to comply with all applicable federal and state regulations concerning human services. Furthermore, the contractor is responsible for ensuring the drivers are trained in defensive driving and in wheelchair securement. A review of a transportation contractor document titled North Carolina Department of Transportation (NCDOT) integrated Mobility Division: Minimum Training Standards) dated January 2022 read in part training must be conducted with new hires and annually thereafter	F 689	All in-house transportation staff were in-serviced on 6/27/2023 by the Transportation Director. This in-service included reviewing the pictures posted in facility van showing the proper way to load/unload residents and re-reviewed the signage posted in the van on the steps to take if an incident/accident happens in the van. This will be trained for all in-house drivers at least yearly. 3. Contract cancelled on March 20, 2023, for outside transportation company. We only use in-house transportation except for ambulance services. 4. The Director of Nursing "DON" will review all incident and accident reports each morning in the daily QA meeting to assure we have completed the root cause analysis to identify if intervention is needed to prevent future incidents/accidents. This audit will be completed for six months, if we see education is continuing to be required, we will extend the audit for an additional six months. The DON will then document this on the audit tool and turn it into the Administrator each month to review in the monthly Quality Assurance Performance Improvement "QAPI" meeting to assure compliance. The DON and Administrator are responsible for ensuring overall compliance. This POC was completed on 6/30/2023.	

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 _____	C 06/30/2023

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 689	Continued From page 20	F 689		

as refreshers training with re-certification. Training topics included wheelchair/mobility device training, securement, and lift/ramp inspection and operation. The contracted van driver completed these trainings upon hiring.

Review of an incident report dated 12/12/22 at 11:36 AM completed by Nurse #3 read in part, Nurse #3 was called to the front of the building and informed that a resident had fallen from her wheelchair onto the lift. Resident #287 stated she had fallen while being escorted from the contracted van by the Contracted Transporter.. Resident #287 had a small bump to the back of her head. She also had some bruising to her right forearm and complained of mid back pain 7 out of 10.

A review of the facility's security video with the Administrator occurred on 6/27/23 at 2:30 PM. The video footage did not contain sound and was partially obscured as Resident #287's wheelchair was seen tumbling from the back of the contracted transportation van without Resident #287 in it. The van's opened back doors partially obstructed the view of the accident and Resident #287 was unable to be viewed falling out of the wheelchair and hitting the grounded gate lift. The video footage showed Resident #287 lying on the grounded lift gate of the van with the Contracted Transporter soon after arriving to Resident #287. Nurse Aide (NA) #3 comes into view and was seen speaking with the Contracted Transporter and then entering the facility as the Contracted Transporter picked up Resident #287 underneath the arms and placed her into the wheelchair. The Contracted Transporter pushed Resident #287 into the facility. Resident #287 was seen entering the facility without any visible blood and pointing

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 _____	C 06/30/2023

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 689	Continued From page 21	F 689		

at the back of her head and did not appear to be in distress.

A review of the statement signed by the Contracted Transporter dated 12/12/22 read in part, "I was unloading Resident #287. While unloading the lift was unfolded without my knowledge, I pushed her out and she fell to the ground. I immediately got down to see if she was okay. Never lost consciousness. She stated she was okay. Got her back in the chair. Again, asked if she was okay, she stated she was still okay. I parked the van and came straight inside. Happened around 11:30. Struck the right side of body".

The Contracted Transporter was unable to be interviewed due to no phone contact information.

Resident #287 was discharged from the facility 1/7/23 and unable to be interviewed.

The Contracted Transportation Supervisor was interviewed via telephone on 6/27/23 at 3:30 PM. The Supervisor reported that the Contracted Transporter was no longer employed with the company. The Supervisor stated she was notified by the facility Administrator immediately after the accident occurred on 12/12/22. The Supervisor did not remember the specific day or time the Administrator had called to inform the plan of correction the facility had put into place. The Supervisor confirmed the Administrator had informed her the plan was that the transportation company van drivers would notify the facility upon arrival and wait for a facility staff to be present when unloading a resident. The Supervisor stated and she was unable to share any additional information.

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 _____	C 06/30/2023

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 689	Continued From page 22	F 689		

The facility's Transportation Supervisor was interviewed on 6/30/23 at 9:10 AM. The Transportation Supervisor reported contracted transporters were not trained or educated by her or the facility. Contracted transporters were trained and certified by the company they worked for, and the contracted van driver received his training from the NCDOT as required for hiring. Furthermore, the Transportation Supervisor stated the facility drivers did not load and unload a resident without additional trained assistant present. The residents were never unloaded facing the front of the van and always had a staff member in direct contact with the wheelchair during the process with a staff in the van and one on the ground.

An interview was conducted with NA #3 on 6/26/23 at 1:53 PM. She stated she observed Resident #287 lying on her left side in the fetal position on the ground behind the van as she entered the parking area returning from her break. The resident's wheelchair was located behind and to the side of lift gate. NA #3 explained she spoke to the Contracted Transporter and instructed him to not move Resident #287 as she was going to find assistance from inside the facility. She observed the Contracted Transporter in the process of moving the resident from the ground but did not observe the Contracted Trasporter placing the resident back into the chair. NA #3 said Resident #287 did not appear in distress and was not yelling or crying.

Nurse #3 was interview on 6/27/23 at 1:40 PM and stated he was paged overhead by the receptionist to go to the front of the building

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 _____	C 06/30/2023

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 689	Continued From page 23	F 689		

because a resident had fallen from a transportation van. The Resident was in the front lobby of the facility sitting in her wheelchair when he arrived, and the Contracted Transporter said he was not paying attention to the resident, and she fell out of the van. Nurse #3 stated he assessed Resident #287 in her room who was alert and talking with complaints of intermittent pain in her back and indicated she hit the back of her head. Nurse #3 explained the NP was in the facility and had the resident sent to the emergency department (ED).

A review of the Nurse Practitioner (NP) assessment note dated 12/12/22 read in part Resident #287 was returning to the facility from dialysis. "The driver of the transit van apparently dropped the patient (Resident #287) from the lift. He (van driver) picked the patient up and put her into the wheelchair to bring her back into the facility. The patient is complaining of acute low back pain. Pain is increased with any movement of her legs". She did hit the back of her head and has a small abrasion or contusion with complaints of a headache. Resident to be transferred to the ED for evaluation.

An interview with the NP was conducted on 6/28/23 at 9:33 AM. The NP stated had assessed the resident when the resident returned to her unit after the fall from the contracted transportation van. The resident had low back pain and when moving her legs. The resident was complaining of a headache as she had hit the back of her head and had a bruise to her right arm. The resident did not lose consciousness, was alert and was not bleeding. The resident appeared uncomfortable and had told her she had been dropped and the Contracted

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 _____	C 06/30/2023

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 689	Continued From page 24	F 689		

Transporter picked her up and put her back into the wheelchair. The NP reported the resident returned to the facility with a diagnoses of a lumbar compression fracture.

A review of Emergency Department (ED) notes dated 12/12/22 revealed the patient's chief complaint was a fall. The patient reported sharp shooting pain back of her head and lumbar spine, non-radiating, constant, and worse with motion. The patient denied any neck pain. The ED diagnostic imaging found a 50% compression of L1 (lumbar) vertebral body. The ED plan of care recommended supportive care measures with a primary care physician follow-up. Resident #287 was provided one tablet of oxycodone 325 milligrams (narcotic pain medication) while in the ED. She discharged from the ED on 12/12/22 and sent back to the facility.

The Administrator was interviewed on 6/26/23 at 1:53 PM. She reported she was notified immediately on 12/12/22 when Resident #287 had fallen from a contracted transportation van in the parking lot and went to the front entrance of the building. Resident #287 was sitting in her wheelchair inside the front door of the facility. The Administrator indicated no one witnessed the fall but the Contracted Transporter and that NA #3 had seen Resident #287 lying on the ground behind the van as she entered the parking area. The resident's assigned nurse was called to the front to assess and take Resident # 287 to her room. The NP was in the facility, assessed the resident and sent the resident to the ED for evaluation. Resident #287 had a fractured L1 vertebrae from the accident. The Administrator stated the driver of the contracted transportation van was interviewed and the security video

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 _____	C 06/30/2023

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 689	Continued From page 25	F 689		

footage was reviewed to see the cause of the accident. The Contracted Transporter had reported he did not know the lift gate was on the ground when he was unloading Resident # 287 and he pushed her out the back of the van causing the accident. The Administrator stated the facility initiated an investigation immediately and was able to get a written statement and an interview from the Contracted Transporter before he left. The Contracted Transporter reported to the Administrator while unloading Resident #287, the lift was unfolded without his knowledge. The Contracted Transporter stated he pushed Resident #287 out of the van, and she fell to the ground. The Contracted Transporter immediately got down from the van to check if she was ok. The Contracted Transporter reported Resident #287 reported to him she was ok, and he placed her back into her wheelchair and he pushed her inside the building. The Administrator indicated he spoke with the Contracted Transportation Supervisor and who stated the Contracted Transporter involved with the accident on 12/12/22 would not be allowed to transport any more residents from the facility. The Contracted Transportation Supervisor informed the Administrator all training for contracted transporters was completed, and up to date with Department of Transportation (DOT) standards. The facility put a new process in place on 12/15/22 and the contracted transporters would notify the facility when a resident returned to the facility. A staff member would be present when residents are being unloaded from the van and stand near the van lift to assure the residents are brought down safely. The Administrator concluded with the front door staff (reception) had been in-serviced on the procedure.

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 _____	C 06/30/2023

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 689	Continued From page 26	F 689		

The Administrator was notified of Immediate Jeopardy on 6/26/23 at 6:10 PM

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

1. Review of the incident and accident and completion of root cause analysis to identify if the facility could have prevented the fall. In review of this incident, the facility felt the facility could not have done anything else to prevent the fall from occurring as the facility was using an outside contractor service and the driver involved had been properly trained on proper transfer of residents on and off the van. The facility was provided with training that was conducted by the outside company for their drivers and proper use of lifts is part of that training. In this incident, the van driver simply forgot the position of where he had left the lift and made a mistake.

2. The facility immediately reported the Transportation Driver to his employer and demanded review of the situation and corrective actions. The facility requested all documentation from the transportation company. The transport company refused to release the actual training for the driver. They did send a blank copy of the DOT training that all drivers complete. The supervisor did verify verbally that training was up to date for the driver.

3. The facility immediately conducted an action plan to address contract transportation services with post-accident policies. Included in this action plan was but not limited to:

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 _____	C 06/30/2023

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 689	Continued From page 27	F 689		

o Working with the Transportation Company to ensure training of all contract drivers that provide services to Skyland Care Center to include the individual involved in the accident. This training includes a request to the transport company alert facility staff prior to assisting residents from the van to stand by and monitor the safety of the transfer. The driver involved in the accident was not allowed to transport any facility residents if he was allowed to continue employment with the transportation company.

o Systemic changes were as follows:

Facility put in place that a facility CNA/Nurse must be present when a contracted company employee unloads a resident from their transport vehicle. We no longer use outside transport companies as of March 20, 2023.

In addition to the steps taken in December 2022 and ongoing to prevent adverse outcomes, and following review that this was an isolated conduct issue of a contracted employee, the Facility has taken and/or modified the necessary steps required by the state operations manual to provide a credible allegation of compliance.

1. The facility terminated its transportation contract in March 2023 and no longer has an outside transport company they currently use.

2. Facility drivers will be in-serviced starting on 6/27/2023 by the Director of Transportation on the facility lift and safety procedures in accordance with the manufacturers' specifications and will demonstrate competency. Transportation drivers will not be allowed to drive the van until they have

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 _____	C 06/30/2023

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 689	Continued From page 28	F 689		

completed the training. The transportation director is keeping track of the training. The transportation drivers were educated that the staff member and resident should be facing out when taking a resident out of the van onto the lift gate. Pictures are posted in the van indicating this.

3. In the future if contract transportation services, are used by the facility, they will be required to provide the same training for their employees and provide documentation of the training for each driver who provides services for the facility before they can transport residents. If they refuse, we will not contract with this company.

4. The Administrator is responsible for all issues related to immediate jeopardy removal.

Alleged IJ removal date: 6/28/23

On 6/30/23 the facility's plan for Immediate Jeopardy removal effective 6/28/23 was validated by the following:
Documentation and interviews with staff. Review of the in-service sign in sheets revealed all transportation staff received education and training of the facility van lifts and safety procedures. Interviewed transportation staff reported they follow the guide instructions posted in the transport vans for operating the lift, securing the wheelchairs and what actions to take if an accident or incident occurs. The transportation guide instructions were observed accessible in the vans along with posted photographs demonstrating residents facing out of the van when unloading. The facility no longer uses any contracted van services.

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 _____	C 06/30/2023

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 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with the Speech/Language Pathologist and staff the facility failed to provide a therapeutic diet as ordered by the physician for 1 of 3 residents reviewed for nutrition (Resident #38). The findings included: Resident #38 was admitted to the facility on 05/31/19. Resident #38's diagnoses included Alzheimer's disease, abnormal weight loss, and severe dementia. Review of the current physician's diet order dated 11/08/21 revealed Resident #38 was to receive a mechanical soft diet with instructions for ground meats with extra gravy or sauce on the side for the meat. Review of the quarterly Minimum Data Set (MDS) dated 03/12/23 revealed Resident #38 was rarely understood or understands and was unable to complete the cognitive assessment, therefore a staff assessment was completed and indicated severe impairment. The MDS revealed the amount of assistance Resident #38 required for	F 808	1. All Dietary Staff was in-serviced by 7/10/2023 on their responsibility on tray line accuracy. All staff and agency staff responsible for delivering trays were in-serviced by 7/10/2023 in the process of checking the accuracy of the resident's tray before delivering to the resident. 2. All Dietary Staff were in-serviced by 7/10/2023 on their responsibility on tray line accuracy. The in-service was as follows: Cook is responsible for checking adaptive equipment, consistency of food, special request such as extra gravy, and likes/dislikes. Dietary Assistant I is responsible for checking adaptive equipment, consistency of food, special request such as extra gravy, likes/dislikes, dessert, salads, and bread. Dietary Assistant II is responsible for checking adaptive equipment, consistency of food, special request such as extra	7/10/23

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 _____	C 06/30/2023

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 808	Continued From page 30	F 808		

eating from staff was supervision with setup help and indicated there had been no known weight loss or gain.

An observation of meal service in the main dining was conducted on 06/28/23 at 12:28 PM. The meal tray for Resident #38 included a diet card with instructions for a bowl of gravy. Resident #38 was served fried chicken of a ground like texture with no bowl of gravy. Nurse Aide (NA) #1 was observed feeding Resident #38 bites of fried chicken with no gravy or sauce on the meat. Gravy was observed to be available on a steam table also located in the main dining room.

During an interview on 06/28/23 at 12:28 PM NA #1 revealed she had read the diet card for Resident #38 that included instructions to have a bowl of gravy. NA #1 stated the kitchen did not have gravy available and she had not asked for it.

An interview was conducted on 6/28/23 at 1:12 PM with the Speech/Language Pathologist (SLP). The SLP revealed the physician's diet order for gravy on the side was to help moisten mechanically altered meat as those might be to dry and hard for Resident #38 to swallow. The SLP stated if the diet order provided instructions to include gravy for meats it should be served with the meal.

An interview was conducted on 06/28/23 at 3:28 PM with the Director of Nursing (DON). The DON revealed she was made aware Resident #38 was not served gravy with the fried chicken and after she spoke with NA staff, they indicated the gravy was only served with breakfast. The DON revealed the gravy was served with meats to make it easier for Resident #38 swallow and she

gravy, likes/dislikes, dessert, salads, bread, and place drinks/supplements.

All staff and agency staff were in-serviced by 7/10/2023 on how to read a tray card, and the process of checking the accuracy of the resident's tray before delivering to the resident.

All new hires will be trained according to their role in the tray accuracy process.

3. There are no systemic changes as it has always been our process to check the trays before delivering to the resident. We are re-educating all staff on their responsibilities on tray line accuracy.

4. The Dietary Manager/Dietitian will complete no less than 10 random tray accuracy audits per week for six months across all three meals. We will assure resident # 38's tray is audited at least 3 times per week during different meals for one month to assure overall accuracy. If the Dietary Manager finds non-compliance with tray accuracy, they will re-educate the employee and use disciplinary action if needed.

The Dietary Manager will turn in the tray accuracy audits to the Administrator weekly. The audit will then be reviewed in the monthly Quality Assurance Performance Improvement "QAPI" meeting.

The Administrator is responsible for ensuring overall compliance.

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 _____	C 06/30/2023

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 808	Continued From page 31 would expect NA#1 to ensure it was provided after reading the instructions on the diet card. An interview was conducted on 06/30/23 at 12:17 PM with the Administrator. The Administrator stated gravy should be served on the meal tray as ordered by the physician for Resident #38.	F 808	The POC completion date was 7/10/2023.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		7/8/23

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 _____	C 06/30/2023

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 867	Continued From page 32	F 867		

development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity

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 _____	C 06/30/2023

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 867	Continued From page 33	F 867		

of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including

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 _____	C 06/30/2023

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 867	Continued From page 34 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following a recertification survey completed on 08/26/21. This failure was for a deficiency originally cited in the area of Quality of Care (F684) on 08/26/21. This continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F684: Based on record review, review of surveillance video, and interviews with staff, the Nurse Practitioner (NP) and Medical Director (MD), the facility failed to assess Resident #287 immediately after a fall from the contracted transportation van. On 12/12/22 Resident #287 was rolled out of the back of the contracted transportation van in her wheelchair and fell to the ground landing on her left side and hitting the back of her head. The Contracted Transporter lifted Resident #287 back into her wheelchair and wheeled her into the facility without being assessed by a licensed professional. The Resident complained of mid back pain at 7 out of 10 (10 being the worst pain) and bruising was noted on her right forearm. Resident #287 was sent to the emergency department for evaluation	F 867	1. The facility's Chief Operating Officer "COO" reviewed the facility quality assurance performance improvement "QAPI" program related to Quality of Care and has in-serviced the administrator and Director of Nursing on July 5, 2023, on steps to take to ensure compliance. The Quality Assurance "QA" Committee has developed a Quality Improvement Audit form to monitor this area of deficiency. This tool will be used by the Director of Nursing daily and a written report will be provided to the Administrator monthly. Any areas of noncompliance will be addressed by the Director of Nursing with the Administrator and corrected immediately. These results will be reported by the Director of Nursing during monthly QAPI meetings. 2. The facility's COO and Administrator reviewed the facility's overall Quality Assurance program on July 5, 2023. The facility's QAPI program was reviewed with the QA Committee, including but not limited to the Medical Director, Director of Nursing, Dietician and Pharmacist to enhance performance improvement auditing activity for past non-compliance areas, to take action, and to achieve compliance. 3. In review of the non-compliance area in the prior year, it was related to Quality of Care. The facility has modified its QA Audit tool in July 2023 to ensure that all	

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 _____	C 06/30/2023

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 867	Continued From page 35 and diagnosed with a compression fracture of the L1 vertebrae. There was the high likelihood of further injury when a resident was moved after a fall before being assessed by a licensed professional. This deficient practice occurred for 1 of 3 residents review for accidents (Resident #287). During the recertification survey of 08/26/21, the facility failed to initiate their bowel protocol when a resident went 6 days with no bowel movement. During an interview on 06/30/23 at 12:17 PM, the Administrator revealed the QA committee met monthly which included all administrative staff and Medical Director. During the monthly QA meetings, they discussed a variety of topics, including quality improvement indicators such as readmissions, and she felt the measures they had put into place were successful. The Administrator revealed the QA committee would be reviewing the areas of concern identified during the current survey and discussing what needed to be done to address and how to improve.	F 867	incident reports are reviewed each morning from the day before and all residents were assessed by a nurse. The COO will review the QA Audit tool to ensure the QAPI meetings address areas of past non-compliance, and effective performance improvement tools are put in place. 4. The QA Audit forms completed by the Director of Nursing will be reviewed in the facility's monthly QAPI meetings for a minimum of one year. Results of the audits will be monitored by the Administrator and reported to the COO and actions taken as necessary to ensure compliance. These actions may include increased auditing, re-education of staff, and disciplinary action, as necessary. The administrator is responsible for overall compliance. This POC was completed on 7/8/2023.	