DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345418**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	**1984 US Highway 70 , Swannanoa, North Carolina, 28778**

(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
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to remove expired food (walk in cooler #1) and failed to remove perishable food with grey and white fuzz (walk in cooler #2) from 2 out of 2 walk in coolers. This practice had the potential to affect food served to residents. The findings included: a. On 9/29/25 at 10:02 AM an initial tour of the kitchen was conducted with the Dietary Manager (DM). During the initial tour it was observed in the walk in cooler #1 four (4) containers (32 ounces each) of vanilla low fat yogurt that were unopened and had a	F0812	The facility failed to remove expired food (walk in cooler #1) and failed to remove perishable food with grey and white fuzz (walk in cooler #2) from 2 out of 2 walk in coolers. This practice had the potential to affect food served to residents. All expired yogurt, expired cottage cheese, and moldy strawberries were immediately discarded by the Dietary Manager (DM) on 9.29.25. No residents were adversely affected. Current facility residents are at risk of being affected by the deficient practice. A 100% audit of all food storage areas was completed. No additional expired or spoiled food was found by Regional Director of Operations (RDO) on 9.29.25. To ensure the deficient practice does not recur the facility has put the following things in place: current facility dietary staff were re educated on inspecting food deliveries for acceptable quality before placing them in their storage areas and any found with any spoilage or expiration will be discarded appropriately; completing daily labeling; dating requirements; and monitoring of refrigerated foods that must be used or discarded by their expiration date by RDO on 10/1/2025. Newly hired dietary staff and staff not educated by 10/6/2025 will be educated upon hire or prior to working their next scheduled shift by the DM. All refrigerated food storage areas will be checked for expired items. If any are found they will be discarded immediately. The DM or designee will complete these audits 5 times a week for 4 weeks; 3 times a week for 4 weeks; then once a week for 4 weeks by the Dietary manager. Data from audits will be brought to the Quality Assurance Performance Improvement Committee by the DM and reviewed for compliance monthly for 3 months and ongoing as indicated. Any deficiencies will result in immediate corrective action and re-education. All corrective actions will be completed by 10.7.25.	10/07/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345418**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	**1984 US Highway 70 , Swannanoa, North Carolina, 28778**

(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
F0812 SS = E	Continued from page 1 best if used by date of August 26, 2025. There was also one gallon size container of cottage cheese that was opened, and half of the product was gone with a best if used by date of August 24, 2025. b. On 9/29/25 at 10:02 AM an initial tour of the kitchen was conducted with the DM. In the walk in cooler #2 an observation was made of one container of fresh strawberries. The container had 2 strawberries covered in grey and white fuzz. On 9/29/25 at 10:15 AM an interview was held with the DM. The DM stated that the expired food in both walk in coolers was a visual oversight. The DM stated that it was her responsibility to check the coolers for expired food and she normally checked the entire kitchen for expired food every morning. The DM also stated she had worked at the facility for one month and was training her team to also be checking the dates of all the food before serving and/or getting food out of a container. On 10/2/25 at 1:57 PM an interview was held with the Administrator. The Administrator expected that the kitchen staff would be looking at the dates and getting rid of food as needed especially if past the use by date and/or had signs of spoilage.	F0812		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews with staff and residents, the facility failed to ensure a resident's accessibility to the light switch that was located behind the bed for 1 out 1 resident reviewed for accommodation of needs (Resident #44). The findings included: Resident #44 was admitted to the facility on 1/1/25 with diagnoses of spinal stenosis.	F0558	The facility failed to ensure a resident's accessibility to the light switch that was located behind the bed for 1 out 1 resident reviewed for accommodation of needs (Resident #44). The over-bed light for Resident #44 was immediately adjusted and replaced with an extendable pull cord so that it is within easy reach while in bed on 10.1.25 by the Maintenance Director. Staff confirmed that the resident is now able to operate her light independently. The resident was interviewed and verified satisfaction with the correction. Current facility residents are at risk of being affected by the deficient practice. A 100% facility audit was completed on 10.3.25 by the Maintenance Director of all resident rooms to ensure over-bed lights are accessible and functioning properly. Any issues identified during the audit were corrected immediately. No other residents were found to be affected. To ensure the deficient practice does not recur the	10/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	**1984 US Highway 70 , Swannanoa, North Carolina, 28778**

(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
F0558 SS = D	Continued from page 2 The 7/19/25 quarterly Minimum Data Set (MDS) assessment revealed that Resident #44 was cognitively intact. She had no impairment of her upper or lower extremities and used a wheelchair for mobility. During an observation on 9/29/25 at 11:50 AM the light switch for the over bed light fixture was located behind Resident #44's bed. There was a pull string/cord that was attached with a broken string that was approximately 10 inches long. It was 3 ½ feet from the floor and 3 feet from the bed. Resident #44 was unable to reach the string/cord from her bed to turn the light on/off when needed. An interview was conducted with Resident #44 on 9/29/25 at 11:55 AM. Resident #44 stated that she had back pain often and so she stayed in her bed much of the time. When asked about the light switch behind her bed Resident #44 stated she would like to use it but couldn't reach it. Resident #44 stated that she had forgotten about the light because the cord had been broken for a long time and could not remember if she had notified the staff when it was first broken. On 10/1/25 at 9:39 AM a follow up interview was conducted with Resident #44. Resident #44 was lying in her bed reading and the room was dimly lit. The light behind the bed was off. Resident #44 was asked if she would like the light on and she stated yes. The light was turned on and she said, "that is much better". Resident #44 was again asked if she would like to be able to turn the light on and off herself and she stated she would. On 10/1/25 at 10:00 AM an interview was held with the Maintenance Director. He stated that he and other maintenance staff went around the facility and fixed the light switch cords on a weekly basis because they often broke. The Maintenance Director could not say when or if the light cord for Resident #44's was fixed at the last go around. The Maintenance Director looked at Resident #44's light switch and agreed it needed an extension added to the cord so that Resident #44 could turn the light on/off. On 10/2/25 at 1:05 PM an interview was held with the Director of Nursing (DON) and she stated that any resident that would like to be able to use the pull cord for the light switch should be able to reach it.	F0558	Continued from page 2 facility as put into place the following. The Maintenance Director and Maintenance Assistant were reeducated on ensuring that they are auditing all resident's over the bed light strings are within reach on a monthly basis and PRN by the Administrator on 10.6.25. All current facility staff were educated in regards to ensuring all over the bed light strings are in working order and can be reached by the resident to operate as independently as possible by 10.6.25 by Administrator and how to report if an issue is noted. All newly hired maintenance staff and facility staff or staff not educated by 10/6/2025 will be educated upon hire or prior to working their next scheduled shift. The Maintenance Director or Designee will audit 5 residents, 5 times a week for 4 weeks; then 3 residents 3 x a week for one month; and 1 resident per week for four weeks to verify compliance. Audit results will be brought by the Maintenance Director and reviewed in the Quality Assurance Performance Improvement Committee meeting monthly for 3 months and ongoing as indicated. Any deficiencies will result in immediate corrective action and re-education. All corrective actions will be completed by 10.7.25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	1984 US Highway 70 , Swannanoa, North Carolina, 28778

(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
F0558 SS = D	Continued from page 3 On 10/2/25 at 2:01 AM an interview was held with the Administrator. She stated that she would expect Resident #44 to have her pull cord available to her but also stated that Resident #44 was able to communicate to staff if she wanted her light on.	F0558		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with residents, pharmacy, medical director, nurse practitioner and staff, the facility failed to implement an effective system to ensure the antidiarrheal medication was	F0755	The facility failed to implement an effective system to ensure the antidiarrheal medication was reordered and available to administer which resulted in 12 missed doses for 1 out of 1 resident reviewed for pharmacy services (Resident #4. Resident's #4 Lomotil was reordered, received, and given on 9.30.25. The medical director was aware that the facility was awaiting the medication and placed it on hold 9.27.25 until it could be reordered on 9.29.25 by the Nurse Practitioner. Resident #4 was assessed with no ill effects noted by the nurse practitioner. Current facility residents who are prescribed antidiarrheal medications are at risk of being affected by the deficient practice. An audit was conducted for all anti-diarrheal medications to ensure adequate supply and proper reorder timing for the last 30 days on 10.6.25, with no issues noted, by Director of Nursing (DON). To ensure the deficient practice does not recur the facility has put the following in place: Current facility and agency licenses nurses were educated on controlled medication procedures, use of electronic medication administration record, and narcotic reorder process by the Staff Development Coordinator (SDC), by 10.6.25. Newly hired facility and licensed nurses and staff not educated by 10/6/2025 will be educated upon hire or prior to working their next scheduled shift. The DON or designee will complete audit of anti-diarrhea medications 5 times a week for 4 weeks, then 3 times a week for 4 weeks, 1 time a week for 4 weeks to ensure medication was available and administered as ordered. Data from audits will be brought to the Quality Assurance Performance Improvement Committee by the DON and reviewed for compliance monthly for 3 months and ongoing as indicated. Any deficiencies will result in immediate corrective action and re-education. All corrective actions will be completed by 10.7.25.	10/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345418**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	**1984 US Highway 70 , Swannanoa, North Carolina, 28778**

(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
F0755 SS = D	Continued from page 4 reordered and available to administer which resulted in 12 missed doses for 1 out of 1 resident reviewed for pharmacy services (Resident #4) The findings included: Resident #4 was admitted to the facility on 7/10/24 with diagnoses of incontinence, end stage renal disease and end stage renal dialysis. The 8/28/25 quarterly Minimum Data Set (MDS) revealed that Resident #4 was cognitively intact. He had a urinary catheter and was always incontinent of bowel. There was a physician order with a start date of 3/18/25 for medication diphenoxylate-atropine (Lomotil)-controlled drug 2.5-0.025 milligrams (MG). Resident #4 was to get 2 tablets four (4) times a day for diarrhea. The September 2025 Medication Administration Record (MAR) showed that Resident #4 was receiving his diphenoxylate-atropine four times a day at 2:00 AM, 8:00 AM, 2:00 PM and 8:00 PM up until 9/27/25. On 9/27/25 starting with 2:00 AM dose it was recorded that the dose was put on hold. On 9/27/25, 9/28/25 and 9/29/25 each of the 4 doses were recorded either on hold or see nurses note. On 9/30/25 the medication was coded to have been given as ordered. On 10/1/25 at 2:44 PM an interview was held with Medication Aide #2. She stated she worked on 9/26/25 and 9/27/25 from 7:00 PM till 7:00 AM. On 9/27/25 she went to administer the 2:00 AM lomotil medication to Resident #4's and saw that he was out of the medication. Medication Aide #2 reported this to the West Side Unit Manager. The West Side Unit Manager told her that she would take care of it. On 10/2/25 at 11:13 AM an interview was conducted with Nurse #4. She stated that she worked on 9/27/25 from 7:00AM until 7:00 PM and when she looked over her medication cart, she noticed that Resident #4 did not have any of his lomotil medication. Medication Aide #2, whose shift was now ending and was giving the keys to the cart to Nurse #4, did not have any information on what was going on with the medication but stated the Medical Director might coming around to do rounds and	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	**1984 US Highway 70 , Swannanoa, North Carolina, 28778**

(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
F0755 SS = D	Continued from page 5 to ask him about it. Nurse #4 stated that the Medical Director never did come in to do rounds. Nurse #4 said that during her shift she changed Resident #4's dressing and his wound looked good, and he was not experiencing any diarrhea. On 10/1/25 at 3:13 PM an interview was held with the West Side Unit Manager. She stated that every Friday the facility had a team meeting to go over medications and for the staff to check their medication carts to ensure they have everything needed for the weekend, especially controlled medications. She stated that on the weekend the on call providers get really upset if they are asked to order a controlled medication. So, the facility tries hard not to make this type of call to the weekend on call provider. She stated they had the medication cart meeting on 9/26/25 and the agency nurse who had the west side cart did not report that the lomotil for Resident #4 was low and needed a new order. On Saturday 9/27/24 the West Side Unit Manager stopped by the facility and when she was at the facility Medication Aide #2 alerted her that there was no more lomotil for Resident #4. The unit manager told Medication Aide #2 that one of the nurses needed to call it in. The Unit Manager also stated she would take care of it and was unsure how she left the conversation for the nurse to take care of it or herself. On 10/2/25 at 9:18 AM an interview was conducted with Nurse #3. Nurse #3 stated she worked the 7:00 AM to 7:00 PM shift on 9/28/25. Nurse #3 stated when she started her shift, she was informed at report that Resident #4's lomotil medication was out. Nurse #3 stated that later that day the west side Unit Manager stopped by and asked if any medications or narcotics needed to be called into the pharmacy and Nurse #3 informed the Unit Manager that Resident #4 needed his lomotil medication. The Unit Manager stated she had already been informed about that medication and that it should be coming in from the pharmacy. During the interview Nurse #3 stated that a nurse can reorder a medication through eMAR but not a narcotic. For a narcotic the nurse would enter the need for a new script in the Nurse Practitioner (NP) book or peel off the medication label on the empty pack and put that in the NP book alerting the NP that it needed to be reordered. Nurse #3 did check Resident #4's skin and spoke to Resident #4 and he knew that he was out of the one medication. Resident #4 was not experiencing diarrhea.	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345418**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	**1984 US Highway 70 , Swannanoa, North Carolina, 28778**

(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
F0755 SS = D	Continued from page 6 On 10/2/25 at 1:17 PM a telephone call was made to the East Side Unit Manager but was unsuccessful. On 10/1/25 at 2:04 PM an interview was held with Medication Aide #1. Medication Aide #1 worked the weekends from 7:00 PM until 7:00 AM. She stated that she worked on Resident #4's hall passing medication on 9/28/25. When she started her shift, she had been informed by a nurse, she could not remember who, that Resident #4 was out of his lomotil medication. Medication Aide #1 stated the nurse told her that the pharmacy had been called to deliver the medication, but by the end of the evening the medication still had not been delivered. Medication Aide #1 stated that as a Medication Aide she can suggest a medication for reorder, but she can't reorder it herself. Medication Aide #1 stated that the assigned Nurse Aide (NA) for Resident #4 informed her that he had a bowel movement and did not mention diarrhea. Medication Aide #1 had also spoken to Resident #4 during her shift, and he had not informed her of any diarrhea. On 10/1/25 at 2:20 PM a telephone call was made to the NA assigned to Resident #4 on 9/28/25 during the 7:00 PM to 7:00 AM shift. Telephone contact was unsuccessful. On 9/30/25 at 9:08 AM an interview was conducted with Resident #4. He stated that on Friday, Saturday and Sunday, meaning this past weekend, he did not receive his anti-diarrhea medication called lomotil. He stated that this was the first and only time the facility ran out of it. He stated that being off the medication for 3 days did not really affect his stools too badly. He stated that he was now back on the medication. On 10/1/25 at 12:11 PM an interview was held with Nurse #2. She stated that she works every other weekend and was working on 9/29/25. She stated that the NP had put the lomotil medication on hold because the facility ran out. Nurse #2 said she called the pharmacy to get a delivery time and the pharmacy told her that it would be delivered sometime that evening. Nurse #2 left her shift at 7:00 PM and the medication had not been delivered. On 10/1/25 at 8:52 AM an interview was conducted with Nurse #1 who was passing out medications on Resident #4's hall. Nurse #1 looked at Resident #4's medication	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345418**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	**1984 US Highway 70 , Swannanoa, North Carolina, 28778**

(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
F0755 SS = D	Continued from page 7 record and stated that it appeared he had run out of the lomotil medication on Saturday 9/27/25. Nurse #1 stated she was unsure what happened but can ensure he currently has plenty of that medication now. Nurse #1 stated that when she was passing out medications and noticed the pill count was low, she reorders the medication right away. She thought the pharmacy delivered to the facility two times a day except on Sunday. On 10/1/25 at 2:23 PM a telephone interview was held with the Pharmacy Representative. The Pharmacy Representative stated that Resident #4's lomotil was delivered to the facility on 9/30/25 at 1:26 AM. The Pharmacy Representative stated that on 9/27/25 there had been a request through the facilities electronic Medication Administration Record (eMAR) by an unknown staff requesting a refill on Resident #4's lomotil medication. Since lomotil was a controlled medication, the pharmacy was unable to fill it without a new order by the provider. The Pharmacy Representative was unable to say if anyone from the pharmacy called to alert the facility that a new order would be needed. The Pharmacy Representative reviewed over their call logs and did not see any telephone calls from the facility to order the lomotil medication. On 10/2/25 at 12:42 PM an interview was conducted with the Director of Nursing (DON). The DON stated that on 9/28/25 the East Side Unit Manager was working, and the East Side Unit Manager called the Medical Director regarding the lomotil medication being out and needing a new script. The Medical Director told the East Side Unit Manager to put the lomotil medication on hold until it came in from the pharmacy. The DON agreed that the nursing staff should know that a controlled medication can't be ordered through eMAR and that a new start date and script would be required. The DON was unsure who tried to order the medication through eMAR on 9/27/25. The DON stated that when staff order medications through eMAR it appears on eMAR that the medication was ordered but it doesn't alert the facility that a new script would be needed. The DON thought staff looked in eMAR and saw that the lomotil was ordered on the 9/27/25 and so the staff was waiting for the pharmacy to deliver. On 10/2/25 at 1:20 PM the Medical Director was interviewed by telephone. He stated that he was notified on 9/28/25 by the East Side Unit Manager that Resident #4's lomotil was out. The Medical Director	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345418**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	**1984 US Highway 70 , Swannanoa, North Carolina, 28778**

(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
F0755 SS = D	Continued from page 8 could not remember what time the conversation happened but stated it was earlier in the day. The Medical Director told the East Side Unit Manager to put the lomotil medication on hold and that it was fine for Resident #4 not to get the medication until Monday when the NP would be in the facility to handle it. The Medical Director did not think it was a significant medication error for Resident #4 missing this medication. The Medical Director stated that Resident #4 had diarrhea all the time and that the lomotil does help but doesn't prevent it. The Medical Director knew that on Monday the NP would be able to get a new script to fill the medication. On 10/1/25 at 11:56 AM an interview was conducted with the Nurse Practitioner (NP). The NP stated that she became aware that Resident #4 had missed doses of his lomotil on Monday 9/29/25. She was unsure what time she was made aware. When staff made her aware she then ordered more of the medication. The NP stated that since the medication was a controlled medication there was a process on how it was ordered, and staff could not just call and get a refill. She stated that she could understand how a nurse may not realize that an antidiarrheal would be a controlled medication. The NP said that Resident #4's diarrhea did come back from not being on the medication, but she did not review it as being a significant medication error. On 10/2/25 at 1:57 PM an interview was held with the Administrator. She stated that did not know much regarding the missed doses of Lomotil and the Administrator was letting the DON handle it.	F0755		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	The facility failed to implement their infection control hand hygiene policy when the Wound Nurse failed to change gloves and perform hand hygiene after wound care for Resident #30 and Resident #18. This occurred for 1 of 5 staff members observed for infection control practices (Wound Nurse). The wound nurse involved was immediately re-educated on proper glove use, hand hygiene, and infection control procedures on 10/01/25, by the Director of Nursing (DON). The employee was observed performing return demonstration of correct glove removal, handwashing technique, and able to verbalize when hand hygiene should be performed. Current facility residents receiving wound care are at risk of being affected by the deficient practice. An audit of 10 resident wound treatments were observed to ensure appropriate hand hygiene procedures were being	10/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345418**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	**1984 US Highway 70 , Swannanoa, North Carolina, 28778**

(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
F0880 SS = D	Continued from page 9 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F0880	Continued from page 9 followed and an audit of 10 staff members was observed demonstrating hand washing/glove removal practices to identify whether similar breaches occurred. Observations during these audits found no other instances of improper glove use and/or hand hygiene. This was completed on 10.6.25 by the Infection Control Preventionist (ICP). To ensure the deficient practice does not recur the facility has put the following in place: 100% of current facility and licensed and unlicensed nursing staff received education and competency validation on hand hygiene and glove use per facility policy and CDC guidelines and this was completed by 10.6.25 by the ICP. Newly hired facility and agency licensed and unlicensed nursing staff and staff not educated by 10/6/2025 will be educated upon hire or prior to working their next scheduled shift by the ICP. The ICP or designee will perform random observations of 5 staff members weekly for 4 weeks, then 3 staff members 3x a week for one month then 1 staff per week for four weeks. Observing for proper glove use and hand hygiene compliance. Results will be brought by the ICP and reviewed in the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months and ongoing as indicated. Any deficiencies will result in immediate corrective action and re-education. 5. All corrective actions will be completed by 10.7.25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	**1984 US Highway 70 , Swannanoa, North Carolina, 28778**

(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
F0880 SS = D	Continued from page 10 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record reviews, and staff interviews, the facility failed to implement their infection control hand hygiene policy when the Wound Nurse failed to change gloves and perform hand hygiene after wound care for Resident #30 and Resident #18. This occurred for 1 of 5 staff members observed for infection control practices (Wound Nurse). Findings included: A review of the facility's Hand Hygiene Policy revised 01/01/25 revealed hand hygiene should be completed before donning gloves and immediately after gloves were removed. 1a. A continuous observation of wound care for Resident #30 was completed with Wound Nurse Practitioner and Wound Nurse on 10/01/25 from 9:11 AM through 9:25 AM. Resident #30 had a sign on her door which instructed staff to don gloves and a gown for high contact resident care activities which included wound care. Personal protective equipment (PPE) was observed on Resident #30's door. The Wound Nurse Practitioner and Wound Nurse performed hand hygiene and donned gown and gloves. Resident #30 was positioned for wound care and the Wound Nurse Practitioner cleaned and assessed Resident #30's wound to buttocks. The Wound Nurse Practitioner removed gloves and gown, performed hand hygiene, and exited the room. The Wound Nurse then applied calcium alginate (an absorbent dressing), ointment to the wound area and applied a bordered dressing. The Wound Nurse failed to remove gloves which were visibly soiled with ointment. Resident #30 stated she had a new reddened area to her right heel. The Wound Nurse assessed Resident #30's right heel area, and still wearing the same gloves, went to door, grabbed the doorknob and opened the door and asked the Wound Nurse Practitioner for skin prep. The Wound Nurse then applied skin prep to Resident #30's right heel reddened area without changing gloves and performing hand hygiene directly after she performed wound care to the buttocks wound. The Wound Nurse failed to remove her gloves, then rolled absorbent pad under Resident	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	**1984 US Highway 70 , Swannanoa, North Carolina, 28778**

(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
F0880 SS = D	Continued from page 11 #30 out and replaced the pad underneath Resident #30. The Wound Nurse failed to remove her gloves and then applied Resident #30's socks, opened the closet door, and obtained heel protectors from the closet and applied heel protectors to Resident #30 feet. The Wound Nurse failed to remove gloves and replaced the sheets and blankets on Resident #30 bed and raised the head of the bed when she pressed buttons on the foot of the bed. The Wound Nurse then grabbed the call bell, placed it within reach of Resident #30, and turned off the overhead light by pulling the string, and pushed the bedside table next to the bed without removing her gloves. The Wound Nurse then removed gloves and gown and performed hand hygiene before she exited the room. 1b. A continuous observation of wound care for Resident #18 was completed on 10/01/25 at 11:51 AM through 12:26 PM. Resident #18 had a sign for Enhanced Barrier Precautions (EBP) (type of isolation) on the room door which instructed staff to don gloves and a gown for high contact resident care activities which included wound care. PPE was observed on Resident #18's door. The Wound Nurse performed hand hygiene and donned a gown and gloves. Resident #18 was positioned for wound care and the Wound Nurse cleaned Resident #18's wound to right hip with gauze, applied skin prep, and prepared packing gauze strip for use. The Wound Nurse pulled her gown up and began touching her scrub pockets with the gloved hands and reached into her pockets and verbalized she was looking for her scissors. The Wound Nurse stated the scissors were left on her treatment cart and removed her gown and gloves and performed hand hygiene before exiting the room. The Wound Nurse retrieved scissors from the treatment cart and reentered the room. The Wound Nurse performed hand hygiene, donned a new gown and gloves, and began packing the right hip wound while holding the scissors in her hand. The Wound Nurse covered Resident #18's right hip wound with a bordered dressing. The Wound Nurse removed gloves and performed hand hygiene. The Wound Nurse applied new gloves and Resident #18 was positioned for wound care to his buttocks. The Wound Nurse cleaned Resident #18's buttocks wound with gauze, applied skin prep, packed buttock wound with gauze strip, cut the gauze strip, and applied a bordered dressing over buttocks wound. The Wound Nurse failed to remove gloves and perform hand hygiene after wound care to buttock wound and grabbed Resident #18's walker to move it closer to him. The Wound Nurse failed to remove gloves or perform hand hygiene and assisted Resident #18 to a standing position, retied her gown, and pulled Resident #18's pants up and buttoned them. The Wound Nurse then discarded trash, removed her gloves and gown and discarded PPE. The Wound Nurse performed hand	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345418**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/06/2025**
NAME OF PROVIDER OR SUPPLIER **Swannanoa Valley Health and Rehabilitation**		STREET ADDRESS, CITY, STATE, ZIP CODE **1984 US Highway 70 , Swannanoa, North Carolina, 28778**	

(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
F0880 SS = D	Continued from page 12 hygiene before she exited the room. An interview with the Infection Preventionist (IP) was conducted on 10/01/25 at 3:46 PM. She stated the Wound Nurse should have changed gloves after wound care was provided to prevent contaminating surfaces. An interview with Wound Nurse was conducted on 10/01/25 at 12:09 PM. The Wound Nurse verbalized understanding that gloves should have been changed after wound care as required by the facility EBP policy. The Wound Nurse stated that she had been educated on EBP when hired and she would normally change gloves and follow EBP policy for wound care. The Wound Nurse reported that due to nervousness, she had forgotten to change gloves and perform hand hygiene after she completed wound care on Resident #30 and Resident #18. The Wound Nurse stated she did not realize she had not changed her gloves or performed hand hygiene before touching multiple surfaces with contaminated gloves. An interview with the Director of Nursing (DON) was conducted on 10/02/25 at 9:52 AM. The DON stated that Resident #30 and Resident #18 required EBP due to wounds. The DON verbalized that staff were expected to follow EBP when wound care was performed per facility's EBP policy. The DON stated that staff should change gloves and perform hand hygiene between wounds and remove soiled gloves and perform hand hygiene after wound care.	F0880		
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/29/25 through 10/02/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D7964-H1. Due to QSO memo 26-01 ALL the posting of this 2567 will be delayed until the resolution of the federal government shutdown. Per CMS guidance issued on 11/14/25 the exit date of this survey was adjusted.	E0000		11/24/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/29/25 through10/02/25. Event ID# 1D7964-H1. The following intakes were investigated: 850730, 850732, 850736, 850743, 850749, 850744, 850747. 11 of 11 complaint allegations did not result in	F0000		11/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	1984 US Highway 70 , Swannanoa, North Carolina, 28778

(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
F0000	Continued from page 13 deficiency. Due to QSO memo 26-01 ALL the posting of this 2567 will be delayed due to the federal government shutdown. Per CMS guidance issued on 11/14/25 the exit date of this survey was adjusted. Per QSO 26-02 the exit date of the survey was changed on 12/3/25 to reflect the date of alleged compliance by the provider.	F0000		