STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyland Terrace and Rehabilitation	**516 Wall Street , Waynesville, North Carolina, 28786**

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/16/26 through 02/19/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: 1E3F9D-H1.	E0000		03/02/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/16/26 through 02/19/26. Event ID# 1E3F9D-H1. The following intakes were investigated 2732340, 2712378,2710189,2747069 and 2748694. 6 of 6 allegations did not result in a deficiency. This survey was originally scheduled to start on 02/02/26 but to QSO 26-04-ALL regarding the federal government shutdown and Winter Storm Gianna that made travel unsafe this survey had to be rescheduled.	F0000		03/02/2026
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F0578	Summary of Incident: Based on record review and staff interviews, the facility failed to update a care plan to reflect a change of code status for 1 of 18 residents reviewed for care plans (Resident #40). Corrective Action for Affected Residents: On 2/17/26, Resident #40's care plan was reviewed and updated by the Minimum Data Set (MDS) nurse #1 to reflect the current Do Not Resuscitate (DNR) code status that was changed on 11/5/25. The updated care plan accurately documents Resident #40's death with dignity wishes and current code status. The updated care plan is in Resident #40's electronic medical record and was communicated to the interdisciplinary team members responsible for Resident #40's care on 2/17/26. Identifying other Residents having the Potential to be Affected: On 2/17/26, MDS nurse #1 and MDS nurse #2 conducted an audit of all current residents to verify that the	02/24/2026

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: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyland Terrace and Rehabilitation	**516 Wall Street , Waynesville, North Carolina, 28786**

(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
F0578 SS = D	Continued from page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to update a care plan to reflect a change of code status for 1 of 18 residents reviewed for care plans (Resident #40). Findings included: Resident #40 was admitted on 11/25/15 with diagnoses of dementia and epilepsy. Resident #40’s care plan was observed on 2/16/26 and noted as most recently updated on 9/16/25. A death with dignity care plan noted Resident #40’s wishes included to attempt cardiopulmonary resuscitation (CPR). A progress note written by the Social Worker on 11/5/25 at 1:27 PM noted Resident #40’s family changed the code status to Do Not Resuscitate (DNR). A physician’s order for Do Not Resuscitate (DNR) was written on 11/6/25. Resident #40’s comprehensive Minimum Data Set (MDS) dated 12/15/25 noted he was rarely or never understood. On 2/17/26 at 2:28 PM during an interview, the SW stated that any new or updated code status forms which were completed would be placed into the physician’s notebook for their review and signature. The physician	F0578	Continued from page 1 documented code status in the medical records, physician’s orders, and care plans is consistent and accurately reflects the most current code status. No other discrepancies were found. On 2/18/2026 The Licensed Nursing Home Administrator (LNHA) provided education to MDS nurse #1 and MDS nurse #2 regarding updating care plans with the most recent and accurate medical information or resident choices per facility policy. Measures put into place or Systemic Changes: On 2/23/26, the Director of Nursing (DON) revised the facility’s process for advanced directives and code status changes to include a requirement that the Social Worker (SW) or designee must notify the MDS Nurse and the DON in writing within 24 hours of any code status change. The revised process requires the MDS Nurse to update the resident’s care plan within 3 business days of notification and document the update in the resident’s medical record. The change of code status will be in effect immediately with the order written for the change, MDS will have three days to update the care plan. On 2/23/2026 the DON educated the SW, MDS Nurses, and licensed nursing staff on the revised process for advanced directives and code status changes. The education included the following components: the process for notifying the interdisciplinary team of code status changes; the timeframe for updating care plans following a code status change; documentation requirements in the medical record; and the importance of timely communication during morning meetings regarding changes in resident status and orders. On 2/23/2026, the DON implemented a Code Status Change Communication Log to be maintained by the SW. This log will document the date of code status change, the resident identifier, the person notified (MDS Nurse and DON), the date of notification, and signature confirmation of receipt of notification. The SW or designee will utilize this log to track and ensure timely notification to the appropriate interdisciplinary team members. On 2/23/2026, the Administrator implemented a standing agenda item for the morning meeting that specifically addresses any advance directive or code status changes from the previous 24 hours. The SW or designee will be responsible for reporting these changes during the meeting, and the meeting minutes will reflect this discussion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyland Terrace and Rehabilitation	**516 Wall Street , Waynesville, North Carolina, 28786**

(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
F0578 SS = D	Continued from page 2 would also write an order for the code status in the resident's chart. The SW confirmed Resident #40's code status was changed from "Full Code" to "DNR" on 11/5/25. She indicated she did not recall if she had informed the MDS nurses of the change in code status or if it had been discussed in the morning meeting after the order had been written. On 2/17/26 at 3:45 PM an interview was conducted with MDS Nurse #1 and MDS Nurse #2. Both MDS Nurses stated they were responsible for making updates to the care plans including any code status changes. MDS Nurse #1 stated care plans were reviewed quarterly during the resident's care plan meeting. MDS Nurse #1 explained she was not aware Resident #40's code status had been changed. Both MDS Nurses said they relied on information reported during the morning meeting for any change of orders or resident conditions. They stated they did not recall Resident #40's code status change had been reported. During an interview on 2/19/26 at 3:16 PM the Administrator stated Resident #40's current code status should be reflected on the care plan. The Administrator explained the care plan should have been updated when Resident #40's code status was changed.	F0578	Continued from page 2 Plan to Monitor Performance: Beginning 2/23/2026, the DON or designee will conduct a random observation audit of 5 residents medical records to ensure 5 care plans were updated within 3 business days of a code status change. Audits will be performed 5 days a week (Monday through Friday) for 2 weeks, then weekly for 6 weeks, then monthly for 2 months. Audits will be submitted to the LNHA weekly for 8 weeks then monthly for 2 months The LNHA or designee will report audit results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 5 months to determine effectiveness of this plan. Negative findings will be addressed by the committee. Additional interventions will be developed, implemented, and monitored by the Committee to ensure sustained compliance. Date of Compliance: 2/24/2026	
F0684 SS = D	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 a record review and staff interviews, the facility failed to have a nurse assess a resident who had fallen prior to moving the resident for 1 of 2 residents reviewed for falls (Resident #34). Findings included: Resident #34 was admitted on 6/30/21 with diagnoses of dementia and heart failure. Resident # 34's annual Minimum Data Set (MDS) dated	F0684	Corrective Action for Affected Residents: On 2/18/26, Resident #34 was assessed by Nurse #3 after being transferred to the bed from being lowered to the floor during a transfer. During the nurse's assessment, a skin tear to the right forearm was identified, cleansed, and bandaged. Vital signs were obtained and were within normal limits. The provider, Director of Nursing (DON), and the resident's family were notified. On 2/19/26, the DON or designee reviewed Resident #34's care plan to ensure appropriate interventions were in place to address fall risk during transfers and behaviors that may escalate during care. On 3/2/26 The DON or designee educated licensed nursing staff and certified nursing assistants (CNAs) assigned to Resident #34's care on the importance of immediately notifying the licensed nurse prior to moving any resident who has been lowered to the floor or has fallen, so that a comprehensive assessment for injury can be completed before the resident is moved. Identifying other Residents having the Potential to be Affected: On 2/23/26, the DON performed audits on all current residents with a history of falls, risk for falls, or behaviors that place them at risk for falls during	03/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyland Terrace and Rehabilitation	**516 Wall Street , Waynesville, North Carolina, 28786**

(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
F0684 SS = D	Continued from page 3 12/24/25 coded her with severe cognitive impairment. She required moderate assistance for transfers. She was coded for having behaviors and falls since her last MDS assessment. Resident #34 was care planned on 1/28/26 for participation in restorative care due to being at risk for falls during transfers and demonstrating poor safety awareness. The care plan included providing moderate assistance during all transfers as an intervention to promote safety. Furthermore, the resident was care planned for a history of physical aggression towards others on 12/1/25. Interventions included to remove the resident from any situation that may be escalating or causing agitation and to assess and anticipate the resident's needs for food, thirst, toileting needs, comfort level, body positioning and pain. A progress note written by Nurse #3 on 2/18/26 at 7:42 AM was reviewed. The note stated that Nurse Aide (NA) #1 notified Nurse #3 that while assisting Resident #34 with dressing and transferring, the resident became combative. NA #1 reported that she had to lower Resident #34 to the floor during the transfer for safety. Upon assessment, Nurse #3 noted no visible deformities and identified a skin tear on the resident's right forearm. Resident #34 reported pain in the right arm. The wound was cleansed, and bandages were applied. Vital signs were obtained and were within normal limits. The provider, Director of Nursing (DON), and the resident's family were notified. NA #1 was interviewed on 2/19/26 at 12:05 PM via phone and confirmed she worked from 11:00 PM on 2/17/26 until 7:00 AM on 2/18/26 (3rd shift). She stated on 2/18/26 she was ending her shift, and she went into Resident #34's room to provide care and dress Resident #34 for the day. NA #1 said she explained to Resident #34 what she was going to do with her. NA #1 said she was able to provide incontinent care with no aggression from the resident. The NA then assisted the resident to the edge of the bed and moved the wheelchair close to the bed in preparation to transfer the resident. She transferred Resident #34 "bear hug" style while not touching the resident's arms. As NA #1 was lifting the resident from the bed, the resident began to be aggressive with hitting and yelling and NA #1 lowered the resident to the fall mat beside the bed. NA #1 stated she called for help and went to the door of the room and asked NA #2 for help. NA #2 and the NA #3 went into the room and transferred the resident from the fall mat into her wheelchair. NA #1 stated once NA #2 and NA #3 entered the room, she had no further interaction with Resident	F0684	Continued from page 3 transfers. The audits included review of the current resident census, resident care plans, and resident Minimum Data Set (MDS) assessments. Measures put into place or Systemic Changes: On 3/2/26, the DON reviewed and revised fall protocols to ensure that when a resident is lowered to the floor or falls, licensed nursing staff must be notified immediately to assess the resident for injury prior to the resident being moved from the floor. The fall protocols will clarify that lowering a resident to the floor during a transfer is considered a fall and requires immediate nursing assessment before the resident is repositioned. On 3/2/26, the DON conducted an in-service for licensed nursing staff, to include agency staff, and certified nursing assistants (CNAs) on the facility's fall protocol, emphasizing the requirement to assess residents immediately after a fall or being lowered to the floor, prior to moving the resident. All staff not in attendance, to include agency staff, will be required to complete the education before starting their next shift. All new staff will be educated by the DON or designee during orientation. Plan to Monitor Performance: Beginning 3/2/26, the DON or designee will conduct audits of four (4) residents who have experienced falls or have been lowered to the floor during transfers during the audit period. The audits will include review of fall incident reports, and nursing documentation of each resident audited to ensure that licensed nursing staff assessed the resident for injury prior to the resident being moved. The audits will be conducted weekly for four weeks, then monthly for three months. The auditor will report the audit findings to the Administrator monthly for 4 months. The Administrator will report audit results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 4 months to determine effectiveness of this plan. Negative findings will be addressed by the committee. Additional interventions will be developed, implemented, and monitored by the Committee to ensure sustained compliance. Date of Compliance: 3/3/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyland Terrace and Rehabilitation	**516 Wall Street , Waynesville, North Carolina, 28786**

(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
F0684 SS = D	Continued from page 4 #34 and let NA #2 handle the incident. NA #2 was interviewed on 2/19/26 at 12:35 PM via phone. The NA stated that on 2/18/26 around 6:45 AM, NA #1 was asking for help outside Resident #34's room. NA #1 told her Resident #34 was hitting her when she was trying to transfer the resident and she had to lower the resident onto the floor. NA #2 and NA #3 went into Resident #34's room and found her sitting on the fall mat with her back against the bed. NA #2 said the resident did not complain of any pain while on the fall mat. NA #3 helped her pick the resident from the mat and place her in the wheelchair. The NA then removed the resident's night gown and found a large skin tear to her right forearm. NA #2 stated she went to get Nurse #3 to look at the skin tear. Furthermore, NA #2 reported that NA #1 told her Resident #34 had been lowered onto the fall mat and that she did not consider this to be a fall. NA #2 stated this was the reason she did not notify the nurse to assess Resident #34 before moving her off the fall mat. On 2/19/26 at 3:29 PM, NA #3 was interviewed via phone. She was with NA #2 on 2/18/26 around 6:45 AM when NA #1 came out of Resident #34's room asking for help. NA #3 stated it was her first shift working at the facility and NA #2 was training her. NA #1 said the resident was fighting her during transfer and she had to set the resident on floor. NA #2 and NA #3 went into Resident #34's room and found the resident sitting on the floor with her back against the bed. NA #3 stated she and NA #2 picked up the resident from the floor and placed her in the wheelchair. Resident #34 was rubbing her right arm while in the chair and then they removed the resident's night gown that revealed a large skin tear to the resident's right forearm. NA #2 then left the room to get Nurse #3 to assess and treat the skin tear. Nurse #3 was unavailable for interview. On 2/18/26 at 4:11 PM the Unit Coordinator was interviewed. She stated Resident #34's incident happened around 6:45 AM on 2/18/26. The Unit Coordinator was informed by Nurse #3, that Resident #34 had a skin tear after NA #1 had to set her on the floor during a transfer. The Unit Coordinator went to Resident #34's room and measured the skin tear. It measured approximately 6.5 centimeters in length. The Administrator was interviewed on 2/19/26 at 2:24 PM. She stated when Resident #34 was lowered to the floor, it was considered a fall. The NAs should have notified the nurse to assess the resident for any injuries before the resident was moved.	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyland Terrace and Rehabilitation	**516 Wall Street , Waynesville, North Carolina, 28786**

(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
F0684 F0842 SS=D SS = A	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F0684 F0842		03/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyland Terrace and Rehabilitation	**516 Wall Street , Waynesville, North Carolina, 28786**

(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
F0842 SS = A	Continued from page 6 §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and resident, staff and Nurse Practitioner (NP) interviews the facility failed to maintain an accurate Medication Administration Record (MAR) for 1 of 1 resident reviewed for medical records (Resident #32). The findings included: Resident #32 was admitted to the facility on 9/24/25 with congestive heart failure. A review of Resident #32's electronic medical record revealed a physician's order dated 11/21/25 for an edema glove to the right upper extremity every shift due to edema.	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyland Terrace and Rehabilitation	**516 Wall Street , Waynesville, North Carolina, 28786**

(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
F0842 SS = A	Continued from page 7 A review of Resident #32's MAR showed Nurse #1 documented on 2/17/2026 for the 7:00 AM shift that the edema glove was in place. An observation on 2/17/26 at 8:23 AM revealed Resident #32 lying in bed with no edema glove noted to her right upper extremity, which was not swollen. An observation and interview with Resident #32 on 2/17/26 at 3:03 PM revealed her lying in bed with no edema glove noted to her right upper extremity, which was not swollen. Resident #32 indicated she had used the glove a few months back when she had swelling but had not needed it for the past month because her arm was no longer swollen. She revealed she didn't like to wear it and would take it off sometimes after staff put it on her. During an observation and interview on 02/18/2026 at 8:43 AM with Nurse #1, she confirmed the glove was not currently on Resident #32's right arm and she was unable to locate the glove. Nurse #1 acknowledged she signed the MAR on 2/17/26 for the 7:00 AM shift indicating the glove was applied and revealed she should not have signed off on it because she did not check to see if the glove was on Resident #32. She indicated Resident #32 had not exhibited swelling in her right arm for approximately a month and a half. An interview on 2/18/2026 at 12:20 PM with the Nurse Practitioner revealed Resident #32 experienced no harm from not having the glove applied on 2/17/26 or during the previous month, as there was no edema to Resident #32's right arm during that time. She indicated when Nurse #1 brought the matter to her attention on 2/18/26 she discontinued the order. On 2/19/2026 at 11:56 AM an interview with the Director of Nursing (DON) revealed she had been in her position for four days. The DON reported that the nurses should not have signed off on the MAR that the edema glove was applied to Resident #32 if they didn't verify it had been applied. An interview on 2/19/2026 at 2:00 PM with the Administrator revealed staff should not have been signing off on something they didn't witness and verify themselves, such as Resident #32's edema glove not being on when they signed off that it was.	F0842		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F0883	Corrective Action for Affected Residents: On 2/17/26, Resident #72's medical record was reviewed	03/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyland Terrace and Rehabilitation	**516 Wall Street , Waynesville, North Carolina, 28786**

(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
F0883 SS = D	Continued from page 8 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F0883	Continued from page 8 by the Director of Nursing (DON) or designee to determine the appropriate pneumococcal vaccination needed per current Centers for Disease Control and Prevention (CDC) recommendations. On 2/28/26, after obtaining a physician order, Resident #72 was administered the pneumococcal conjugate vaccine 20 (PCV20) as evidenced by documentation in the medical record, bringing the resident into substantial compliance with federal regulations. Identifying other Residents having the Potential to be Affected: On 2/25/26, the DON conducted an audit of the medical records for all residents currently residing in the facility to identify residents who have consented to receive the pneumococcal vaccine but have not received the recommended pneumococcal vaccination per current CDC guidelines. Any resident identified that had requested but had not received a pneumococcal vaccination was administered the appropriate pneumococcal vaccine following facility policy. Measures put into place or Systemic Changes: On 2/19/26, the DON in-serviced the Infection Preventionist and other nurses responsible for administering vaccine that residents who have consented to the pneumococcal vaccine should receive it in a timely manner following current policy. Attendance records will be maintained. New Infection Preventionists and other nurses responsible for vaccine administration will be educated on hire during orientation. On 2/25/26, a paper vaccine tracking log was implemented to monitor residents who have consented to receive any vaccination and track the status of vaccine administration. The log includes resident identifier, date of consent, prior vaccination history, recommended vaccine due per CDC guidelines, date physician order was obtained, and date vaccine was administered. Plan to Monitor Performance: Beginning 3/2/26, the DON will conduct random audits on 8 residents vaccination records, who have consented to any vaccination. Audits will be conducted weekly for four weeks, then monthly for three months to ensure that residents who consent to vaccination receive the vaccine, following timeframes outlined in facility policies. The DON will report the audit findings to the Administrator monthly for 4 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyland Terrace and Rehabilitation	**516 Wall Street , Waynesville, North Carolina, 28786**

(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
F0883 SS = D	Continued from page 9 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to administer a pneumococcal vaccine to a resident who had consented to receive the vaccine for 1 of 5 residents reviewed for pneumococcal vaccines (Resident #72). Findings included: Resident #72 was admitted to the facility on 2/18/25. The quarterly Minimum Data Set (MDS) dated 11/19/25 indicated Resident #72 had severe cognitive impairment. Review of Resident #72's medical record revealed no documentation that staff had administered a pneumococcal vaccine. The prior pneumococcal immunization history documented revealed a history of Prevnar 13 (pneumococcal 13-valent conjugate) dated 2/11/16. Review of Resident #72's medical record revealed a form titled 'Vaccine Consent Form 2025'. The pneumonia vaccine was marked under the section titled Individual Requests the Following Vaccination(s). The vaccine consent signature section showed that Resident #72's Responsible Party signed the consent for the pneumococcal vaccine on 9/03/25. An interview on 2/17/26 at 11:16 AM with the Director of Nursing (DON) who also served as the Infection Preventionist for the facility. She stated she assessed and administered immunizations for all new admissions and ensured all residents received vaccines and were up to date per Centers for Disease Control and Prevention (CDC) Guidelines. She stated that the current CDC guidelines recommend pneumococcal conjugate vaccine 20 (PCV20) for residents to be up to date. She explained that she used a CDC algorithm with the resident's prior vaccines to help her determine when a resident needed a vaccine to stay up to date. She entered Resident #72's prior vaccines and stated that the resident should have had the PCV20 to be up to date. She was unable to say why this had not been done.	F0883	Continued from page 9 The Administrator will report audit results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 4 months to determine effectiveness of this plan. Negative findings will be addressed by the committee. Additional interventions will be developed, implemented, and monitored by the Committee to ensure sustained compliance. Date of Substantial Compliance: 3-02-26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyland Terrace and Rehabilitation	**516 Wall Street , Waynesville, North Carolina, 28786**

(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
F0883 SS = D	Continued from page 10 An interview on 2/91/26 at 10:06 AM with the Administrator stated she expected resident vaccines to be kept up to date, and she did not know why staff had not administered the PCV20 vaccine Resident #72.	F0883		