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 10/22/2021

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 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted 10/19/21 through 10/20/21 with exit from the facility on 10/20/21. Additional information was obtained through 10/22/21. Therefore the exit date was changed to 10/22/21. There were 9 allegations investigated and one was substantiated. Event ID# QRBF11.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		10/27/21

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

Electronically Signed | 11/04/2021

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F 580	Continued From page 1 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify a resident's legal representative of an order for a medication. This occurred for 1 of 2 residents reviewed for notification of change (Resident #1). Findings included: Resident #1 was admitted to the facility on 1/7/21with diagnoses that included hypertensive heart disease with heart failure and unspecified dementia with behavioral disturbance. The quarterly Minimum Data Set (MDS) dated 9/30/21 revealed Resident #1 was severely cognitively impaired.	F 580	1.The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited. Plan: 1. All nurses will be re-trained on the order process and notifying the responsible party. 2. All new nurses will be trained on the order process and notifying the responsible party. 3. All nurses will be trained to document on the top of the order the name of the responsible party notified. 4. All Administrative nurses will be trained on the new process of checking orders	

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F 580	Continued From page 2 Review of a physician's order, dated 9/24/21, revealed an order for Trazadone 50 milligrams (mg) take one half of a tablet for total dose of 25 mg by mouth at hs (bedtime) as needed for agitation and anxiety for one week. Review of the medication administration record revealed one dose was documented as given on 9/24/21 at 10:44pm. An interview, conducted with the Assistant Director of Nursing (ADON) on 10/22/21 at 10:00am, revealed on 9/24/21, she was entering new orders into the computer. The Director of Nursing (DON) was notifying the responsible parties of the new orders. The ADON stated the DON told her that the order for Trazadone 50mg one half tab at bedtime needed to be discontinued since Resident #1's responsible party did not want her to be on Trazadone. The ADON was under the impression the DON would contact the physician and get the Trazadone order discontinued. An interview, conducted with the Director of Nursing (DON) on 10/22/21 at 10:30am revealed on 9/24/21, she was responsible for notifying the responsible party of Resident #1 of the new medication order. She stated she knew that the responsible party would not want Resident #1 on the Trazadone. She stated she told the ADON to discontinue the order. She thought the ADON had discontinued the order for the Trazadone. The order failed to get discontinued on 9/24/21. The order was active and Trazadone 25mg was given on 9/24/21 in the evening. On 9/27/21, the DON notified the responsible party that Trazadone 25mg was ordered for agitation and was given one time only on 9/24/21 at 10:44pm. The DON	F 580	from the previous day the following morning to assure that the responsible party has been notified and is documented on the order. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. 1. The administrator trained all nurses by 10/26/2021 on the process of taking off physician orders from the chart, notifying the responsible party, and documenting on top of the order who they spoke with. 2. The administrator trained the Administrative RN and all other administrative nurses on 10/25/2021 on the new process of checking orders from the previous day the following morning to assure that the responsible party has been notified. 3. The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. 1. The administrative RN or designee will check all orders from the previous day each morning and sign off that all orders were verified, and responsible parties were notified. The Director of Nursing or Designee will verify each day that all orders have been checked for the next six months. The signed report will then be turned in each month to the administrator and reported in the QAPI meetings. 4. The title of the person responsible for	

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F 580	Continued From page 3 stated there was a communication gap between her and the ADON and she failed to discontinue the order and she failed to notify the responsible party when the Trazadone was ordered on 9/24/21. Attempts to contact the responsible party by telephone were made on 10/19/21 at 2:00pm, 10/20/21 at 9:30am and on 10/20/21 at 3:20pm. Messages were left with no return calls. A telephone interview, conducted with the Administrator on 10/22/21 at 1:38pm, revealed the responsible party should have been notified of the new order for Trazadone.	F 580	implementing the acceptable plan of correction. Director of Nursing Date Back in Compliance: 10/27/2021	