STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345411	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND TERRACE AND REHABILITATION	516 WALL STREET WAYNESVILLE, NC 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
F 000	INITIAL COMMENTS An complaint investigation survey was conducted on 04/29/25 through 04/30/25. Event ID: JVET11. The following intakes were investigated: NC00229237, NC00227764, NC00227574, and NC00227520. 3 of the 10 complaint allegations resulted in deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, family, and staff interviews, the facility failed to protect a resident's right to be free from abuse when a family member (Family Member #1) hit Resident #1 on the leg, covered her mouth with her hand, and told her to shut up. This affected 1 of 3 residents reviewed for abuse (Resident #1).	F 600	Summary of Incident and Findings Resident Abuse Action Plan A. Corrective Actions taken for the Resident affected by the deficient practice: 1. CNA #1 was standing at the door and witnessed Resident #1's daughter hit Resident #1 on the leg and cover her	5/17/25

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

Electronically Signed | 05/15/2025

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F 600	Continued From page 1 Findings included: Resident #1 was admitted to the facility on 2/5/24. Her diagnoses included: hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stoke) affecting left non-dominant side. The annual Minimum Data Set (MDS) assessment dated 2/1/25 revealed Resident #1 was cognitively intact. She was not documented on the MDS as having behaviors or rejection of care. The MDS indicated she used a wheelchair, had function limitations in range of motion to her upper and lower extremities on one side, and was dependent on staff for toileting, dressing, personal hygiene, transfers, and mobility. Review of a facility submitted investigation report specified an allegation of abuse for Resident #1 was reported to the facility Administrator on 2/19/25. The report indicated a Nurse Aide (NA #1) observed Family Member #1 "hitting her [Resident #1] on the leg, covering her mouth and nose with her hand, and telling her to shut up". The investigation reported that NA #1 immediately intervened and reported the incident to the Unit Coordinator (UC #1). The investigation report further revealed that UC #1 removed Family Member #1 from Resident #1's room, interviewed Family Member #1 regarding the incident, and informed Family Member #1 of the investigation process for when an abuse allegation was made. Family Member #1 was informed she could not visit Resident #1 until the investigation was completed. UC #2 escorted Family Member #1 to obtain her belongings from Resident #1's room and then escorted Family Member #1 out of the facility. The allegation of	F 600	mouth and nose with her hand, pushing her head back and “whisper” yelling at her to stop talking while Resident #1 was on the phone. CNA #1 entered the room and told the daughter that she could not be doing that in this facility. CNA #1 asked for help and Nurse #1/ South Unit Coordinator came to the room and escorted the daughter from the room and took her to the Unit Coordinator’s office and had Nurse #2/North Unit Coordinator present with her during the conversation and explained that she would have to leave the facility due to her slapping Resident #1’s leg and covering her mouth with her hand and that administrative staff would contact her regarding future visits with Resident #1. Nurse #2/North Unit Coordinator went with her back to Resident #1’s room and let her gather her belongings and then escorted the daughter from the facility. 2. Nurse #1/South Unit Coordinator then contacted the Administrator and the Director of Nursing and reported the incident to them. 3. The facility initiated an investigation and reported the allegation to the North Carolina Department of Health and Human Services (NCDHHS) Complaint Intake on 02/19/2025. 4. The facility Social Worker reported the incident to the local county Department of Social Services, Adult Protective Services, on 02/19/2025. The Administrator called the local police department on 02/19/2025 at 2:00PM and reported the allegation of resident abuse. 5. The Administrator called the alleged	

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F 600	Continued From page 2 abuse involving Resident #1 was immediately reported to the Administrator by UC #1. The investigation report revealed the facility reported the incident to the local law enforcement agency, the local department of social services, and to the department of health and human services. The facility investigation revealed the facility substantiated the abuse allegation due to NA #1 witnessing the alleged abuse incident. The investigation indicated the perpetrating Family Member #1 was contacted by the Administrator on 2/21/25 and a care plan meeting was arranged for 2/24/25 to establish a supervised visitation schedule for Resident #1's Family Member #1 to visit. An interview was conducted with NA #1 on 4/29/25 at 12:50 PM. NA #1 recalled the incident from 2/19/25 with Resident #1 and Family Member #1. NA #1 said she had been standing in Resident #1's doorway to pass drinks for lunch. NA #1 reported Resident #1 had been talking to someone on the phone. She remembered Family Member #1 kept telling Resident #1 to hush and stop talking to whoever was on the phone. She reported she heard Resident #1 say "have you talked to [Family Member #1] about letting me come stay with you". NA #1 reported that was when Family Member #1 became upset and hit Resident #1 with an open hand on her right thigh. NA #1 stated she was able to hear the noise from the smack when Family Member #1 hit Resident #1 on the leg. NA #1 reported she then saw Family Member #1 put her hand over Resident #1's mouth and nose with enough force to push Resident #1's head back and told her to shut up. NA #1 said she walked into the room and told Family Member #1 to stop. NA #1 reported Family Member #1 stopped and immediately started	F 600	perpetrator, resident's daughter, on 02/19/2025and discussed the facility's process regarding the investigation. The daughter was informed that she would not be allowed to visit until a care plan was held and a supervised visitation schedule was implemented. The Administrator called the daughter on 02/21/2025 and coordinated the care plan with the daughter's schedule and it was scheduled for 02/24/2025. The facility Social Worker, Nurse #1/South Unit Coordinator and the facility MDS Coordinators were present for the care plan and a supervised visitation schedule was developed according to the daughter's preferences and will be implemented and continued for at least three months and longer if needed to ensure the safety of the Resident #1. At the end of the three months, another care plan will be held to determine if supervised visits need to be continued. 6. Staff were educated by the Administrator or designated Department managers on the definition of abuse, which is defined as the willful infliction of injury; unreasonable confinement; intimidation; or punishment; resulting in physical harm, pain, or mental anguish, by any individual within the facility including staff members, other residents, family or responsible parties, contractors or vendors. Education also included the facility's policy of reporting abuse to the Director of Nursing or Administrator immediately. Staff members that were not available will be educated prior to beginning their next shift, this includes all agency staff members. New hires will be	

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F 600	Continued From page 3 crying. NA #1 said Family Member #1 told her to mind her business, it's okay. NA #1 reported she immediately stuck her head out of the room door and called for NA #2 and asked her to go get the supervisor. NA #1 stated she stayed in the room with Resident #1 and Family Member #1 until the supervisor came to the room. NA #1 said Family Member #1 did not say anything else to Resident #1. She reported that UC #1 and UC #2 came to Resident #1's room and removed the family from the room. NA #1 recalled Resident #1 had been calm and then when she asked the question about going and staying with the other person that was when Family Member #1 burst out. NA #1 said she had not heard or seen Family Member #1 do anything like that before. An interview was conducted with Resident #1 on 4/29/25 at 9:40 AM. Resident #1 recalled the incident with Family Member #1. She said Family Member #1 was upset that day. Resident #1 explained she had called Family Member #3 to ask them to come and take her to see a friend so they could pray for her. She explained Family Member #1 had been upset because she had called Family Member #3 asking them to come and get her. She said Family Member #1 got emotional and was crying. Resident #1 said the staff had thought it was upsetting her but that Family Member #1 was not physically hurting her. Resident #1 explained she and Family Member #1 were talking loudly that day. Resident #1 recalled Family Member #1 had said, "Mother you know you can't go out of here unless they take you in the van". Resident #1 did not remember Family Member #1 yelling at her loudly. She said Family Member #1 was "fussing at her" because she had called Family Member #3. Resident #1 said Family Member #1 "loves me and wants	F 600	educated on the definition of abuse and reporting requirements during their new hire orientation. B. Identify others that can be affected by the deficient practice and corrective actions taken: With this particular incident, there are no other residents that were affected by this practice. This was an isolated incident involving the resident's daughter, who does not have contact or socialize with other residents. All residents have the potential to be affected by possible abuse from family members or visitors. The facility Abuse, Neglect, Exploitation and Misappropriation of Resident Property policy is included in the admission packet and is given to residents and families/responsible parties upon admission. A copy of the facility Abuse, Neglect, Exploitation and Misappropriation of Resident Property policy was given to the alert and oriented residents, and the residents were educated about their right to be free from abuse, neglect, exploitation and misappropriation of resident property and encouraged to please report anything that happens to them or if there is anyone that makes them feel uncomfortable during a visit. Education will also be provided at the monthly Resident Council meeting for the next three months. Staff were also educated to pay attention when visits are taking place and be aware of the residents that would not be able to report due to their cognitive ability.	

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F 600	Continued From page 4 what is best for me". Resident #1 stated Family Member #1 "put her hand over my mouth because she just wanted me to stop talking about it I guess but she was not trying to smother me". "She put her hand over my mouth like saying hush Mom, but she did not do it to hurt me". Resident #1 did not recall Family Member #1 hitting her on her leg. Resident #1 reported she did not remember if Family Member #1 had told her to shut up. Resident #1 said Family Member #1 had never physically hurt her. She reported it did not bother her how Family Member #1 talked to her or when she fussed at her. Resident #1 stated "they just don't know what a loving child is". An interview was conducted with UC #1 on 4/29/25 at 11:35 AM. UC #1 recalled the incident from 2/19/25 with Resident #1 and Family Member #1. UC #1 explained it was reported NA #1 had witnessed Family Member #1 hit Resident #1 on the leg, cover her mouth and nose, and tell her to shut up. UC #1 stated she had been with UC #2 when the incident was reported to her and UC #2 went with her to Resident #1's room. UC #1 reported when she and UC #2 entered Resident #1's room she asked Family Member #1 to leave Resident #1's room to go talk. She remembered Family Member #1 started arguing. She said Family Member #1 was not yelling but was loud and aggressive in tone and stated Resident #1 needed to hear this too. UC #1 reported she told Family Member #1 they needed to discuss it outside of the room. UC #1 stated she and UC #2 took Family Member #1 to her office to talk. UC #1 explained Family Member #1 and Resident #1 had been arguing because the night before Resident #1 had called Family Member #3 wanting them to come and pick her	F 600	C. Were there any systemic changes necessary to comply with F600? There were no systemic changes necessary as the facility has policies in place regarding resident abuse and staff implemented the policy exactly as written. The facility Abuse, Neglect, Exploitation and Misappropriation of Resident Property policy is in the facility admission packet and is given to residents and families/responsible parties upon admission. D. How you plan to monitor through the facility Quality Assurance Performance Improvement program to ensure compliance: The supervised visits will be reviewed monthly in the Quality Assurance meeting and in three months, the Interdisciplinary Department Team will determine if the supervised visits need to continue to ensure the safety of Resident #1 in the Quality Assurance meeting. The Administrator and/or the Director of Nursing will be responsible for ensuring that the plan of correction is followed and reviewed through the Quality Assurance meetings. E. Date of Compliance: 05/17/2025	

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up and take her to go see a friend to pray over her. She recalled Family Member #1 expressed she was frustrated because she felt Resident #1 knew not to call people to come get her because they could not come get her and it had been the middle of the night when Resident #1 had called them. UC #1 said Family Member #1 was upset Resident #1 had called them. UC #1 reported Family Member #1 denied hitting Resident #1. UC #1 stated Family Member #1 said she had grabbed Resident #1 by the shoulders but had denied covering her mouth with her hand. UC #1 recalled Family Member #1 said she did not remember if she had told Resident #1 to shut up. UC #1 said she explained to Family Member #1 she could not touch Resident #1 in an aggressive and negative way. UC #1 stated she told Family Member #1 she needed to leave the facility until further instruction was received by the Administrator. UC #1 recalled UC #2 accompanied Family Member #1 to obtain her belongings from Resident #1's room and escorted her out of the facility. UC #1 stated she called the Administrator immediately and reported the incident while UC #2 escorted Family Member #1 out of the facility. UC #1 stated after the incident she completed a skin assessment on Resident #1 and did not find any marks. UC #1 recalled she interviewed Resident #1 after the incident. She reported Resident #1 denied Family Member #1 hit her but did say Family Member #1 had told her to shut up. UC #1 stated Resident #1 said she could not remember if Family Member #1 covered her mouth. UC #1 stated after the incident Resident #1 seemed upset and said, "I know better than to call others and ask for things, I know [Family Member #1] takes care of things". UC #1 reported Family Member #1 now had scheduled supervised visits with Resident #1.

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She voiced there had not been any further issues since the supervised visits were put into place.

An interview was conducted with UC #2 on 4/29/25 at 12:00 PM. UC #2 said she had been with UC #1 when it was reported NA #1 had witnessed Family Member #1 slap Resident #1 on the leg and covered her mouth. UC #2 explained she had gone to Resident #1's room with UC #1 after the incident was reported. She recalled when they went to the room Family Member #1 was upset and seemed to know there was an issue. She said Family Member #2 was also visiting and present in the room but did not say much. UC #1 said Resident #1's Family Member #1 was frustrated because Resident #1 called people and asked them to take her places and Resident #1 did not understand she could not get in or out of a car and they could not come get her. She said Family Member #1 was frustrated because Resident #1 kept doing this. UC #2 reported she and UC #1 removed Family Member #1 from Resident #1's room and took her to UC #1's office to ask her what happened. She recalled Family Member #1 said she did not hit Resident #1 and denied covering her mouth. UC #2 reported after talking to Family Member #1 they told her the incident would be investigated but that she needed to leave the facility. UC #1 explained she took Family Member #1 back to get her things from Resident #1's room and then escorted her out of the building.

An interview was conducted with Family Member #1 and Family Member #2 on 4/29/25 at 2:00 PM. Family Member #1 explained Resident # 1 had been sitting with her head hanging down. Family Member #1 said she picked up Resident #1's head at her chin and tilted her head up, but not

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violently to get Resident #1 to look at her. She stated Resident #1 would have screamed if it had hurt her. She reported Resident #1 was talking on the phone and she had not been responding to the person on the phone. Family Member #1 said she did not slap or hit Resident #1 on her leg. She explained in the past she had patted Resident #1 on the leg to get her to lift her leg to get her feet back on the footrest of her wheelchair. Family Member #1 explained she did that often but did not remember specifically if she did it that day. Family Member #1 said she did not remember putting her hand over Resident #1's mouth. When asked if she remembered telling Resident #1 to shut up, Family Member #1 said, "I don't know". Family Member #1 stated she did not have a habit of telling Resident #1 to shut up and did not recall telling her to shut up. Family Member #1 reported when NA #1 came into Resident #1's room NA #1 said "that is not acceptable get your hands off her". Family Member #1 stated she told NA #1 it was none of her business because she had not perceived the situation as her doing something that was harmful to Resident #1. Family Member #1 reported she had not been arguing with Resident #1 that she had just been trying to get her to pay attention. She stated UC #1 and UC #2 came and talked to her and asked her to leave that day. Family Member #1 reported that the Administrator called and talked to her after the incident and set up a care plan meeting for 2/24/25 to set up supervised visits. Family Member #2 was present during the interview and said Family Member #1 had been trying to get Resident #1 to pay attention that day. Family Member #2 said Family Member #1 would never hurt Resident #1. Family Member #2 did not provide any additional details from the incident.

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An interview was conducted with the Director of Nursing (DON) on 4/29/25 at 5:05 PM. The DON recalled the incident with Resident #1 and Family Member #1 that occurred on 2/19/25. She reported the Administrator had completed most of the abuse investigation. The DON stated Resident #1 had said it did not happen when they talked to her. The DON reported she thought Resident #1 said it did not happen because Resident #1 was trying to protect Family Member #1. The DON explained the facility substantiated the abuse allegation because the incident had been witnessed by NA #1. She reported NA #1 had witnessed Family Member #1 hit Resident #1 on the leg, cover her mouth, and tell her to shut up. She said Family Member #1 had denied all allegations when they spoke with her. The DON stated Resident #1 did not act afraid of Family Member #1 and wanted her to visit. She reported after the incident a care plan meeting was held with Family Member #1 to set up scheduled supervised visits. The DON reported there had not been any further issues since supervised visits had been implemented.

An interview was conducted with the Administrator on 4/30/25 at 11:54 AM. The Administrator said on 2/19/24 she received a phone call from UC #1 reporting the allegation of abuse to Resident #1 by Family Member #1. She stated it was reported that NA #1 was at Resident #1's door looking into the room and saw Family Member #1 put her hand over Resident #1's mouth, pushed her head back while covering her nose and mouth, and saying shut up stop talking. The Administrator said it was also reported that Family Member #1 hit Resident #1 on the leg, she was not sure if it was with an open hand or how

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hard the hit was. The Administrator stated NA #1 intervened, and the incident was reported to UC #1. The Administrator said Family Member #1 was escorted out of the building after the incident. She reported UC #1 had immediately called her after the incident happened to report it. The Administrator stated she called Family Member #1 the same day on 2/19/25. She reported Family Member #1 said she would never hurt Resident #1 and denied it happened. The Administrator stated they had substantiated the abuse allegation due to the incident being witnessed by NA #1. The Administrator said a care plan meeting was set up with Family Member #1 to establish a supervised visitation schedule to preserve Resident #1's visitation rights.