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 12/06/2024

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/02/24 through 12/06/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #B8P811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/02/24 through 12/06/24. Event ID# B8P811. The following intakes were investigated NC00210422, NC00211968, NC00217519, NC00221211, NC00224762, and NC00224863. 3 of the 20 complaint allegations resulted in deficiency.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff, and Senior Police Officer interviews, the facility failed to protect the resident's right to be free from misappropriation of resident property. This deficient practice was for 1 of 1 resident reviewed for misappropriation of resident property (Resident #78).	F 602	Summary of Incident and Findings An interview with resident #78 revealed that she had five missing rings. She had gone out of the facility with her family for Thanksgiving and the family had given her the rings to wear. She returned to the facility with the rings on Thanksgiving	12/20/24

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

Electronically Signed | 12/19/2024

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F 602	Continued From page 1 The findings included: Resident #78 was admitted to the facility on 10/29/24 with diagnoses which included gastrointestinal hemorrhage and hypertension. The admission Minimum Data Set dated 11/04/24 revealed Resident #78 was cognitively intact. Review of the initial facility report dated 11/30/24 at 10:30 AM documented that Resident #78 reported her wedding rings and mother's ring were missing. An interview with Resident #78 12/05/24 at 9:56 AM revealed that there were 5 rings missing. She stated that her family had taken her out on Wednesday, 11/27/24, to get a manicure for Thanksgiving. At that time, her family had given her 5 rings to wear for Thanksgiving on 11/28/24. She stated that she wore them out with her family on 11/28/24 and had them in her possession when she returned to the facility. She wore them at the facility on Friday, 11/29/24 and took them off at bedtime. Resident #78 stated she put them in a plastic bag when getting ready for bed on 11/29/24 and put the bag on her bedside table. When she got up the next morning on Saturday, 11/30/24, she got dressed and ready for the day. She got the bag from her bedside table to put her rings on and the rings that were in bag were not her rings. There were 4 cheap replacements rings. She stated she reported to staff about her missing rings. She stated she feels sad that her rings are missing as they were gifts from her husband, and she had bequeathed them to her family.	F 602	evening and on Friday night, 11/29/2024, when she was getting ready for bed, she took the rings off and placed them in a plastic bag and placed them on her overbed table. Saturday morning, 11/30/2024, when she took the jewelry out of the plastic bag her rings were not there and there were different rings in the bag. F602 Action Plan 1. Corrective Actions taken for the Resident affected by the deficient practice: a. When the facility was made aware of the alleged incident, an investigation was initiated and reported to the North Carolina Department of Health and Human Services (NCDHHS) Complaint Intake on November 30, 2024. b. The facility interviewed all alert and oriented residents with a Brief Interview of Mental Status (BIMS) score of 11 or greater to determine any other possible misappropriation of resident property. c. The facility also contacted the family/responsible party of the residents with a Brief Interview of Mental Status score of less than 11 to see if they had any knowledge or concerns of missing property. d. The facility searched the resident's room and searched other resident's rooms that agreed for staff to look through their belongings to try to find the reported missing rings. Other areas of the facility were searched.	

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F 602	Continued From page 2 An interview on 12/05/24 at 12:13 PM with Medication Aide (MA) #1 revealed she was assigned to provide medications for Resident #78 on Wednesday, Thursday, and Friday (11/27/28 through 11/29/24) day shift. She stated she saw the resident's nails on Thursday and observed she was wearing rings. She stated she remembered one looked like an engagement or wedding ring and that there was more than one ring, but did not remember specifically what they looked like. An interview on 12/05/24 at 11:41 AM with Nursing Assistant (NA) #5 revealed she was assigned to provide care for Resident #78 on the day shift Wednesday, Thursday, and Friday (11/27/28 through 11/29/24) as well as the evening shift of Friday. She stated she had not observed if the resident was wearing rings or not. She stated she had helped Resident #78 to bed on Friday evening and had not noticed any rings. An interview on 12/05/24 at 5:40 PM with NA #2 revealed she was assigned to provide care for Resident #78 on Friday 11/29/24 from 3 PM until Saturday 11/30/24 at 7 AM. She stated she did not recall any rings. She stated she did not remember that night specifically, if she assisted the resident to bed, or anything about jewelry. An interview on 12/05/24 at 3:27 PM with NA #4 revealed she was assigned to provide care for Resident #78 on Saturday, 11/30/24. She stated as she was assisting resident to get up, the resident was crying and told her that her rings were missing. She notified the nurse. An interview on 12/05/24 at 1:28 PM with Nurse #1 revealed she was assigned to provide care for	F 602	e. All staff that worked during the time in question were interviewed regarding knowledge of the reported missing jewelry, they reported no knowledge or knowledge of the items missing after the fact. f. The Licensed Nursing Home Administrator (LNHA) reported the allegation of missing jewelry to the Waynesville Police Department and to the Haywood County Department of Social Services, Adult Protective Services Intake worker. g. The Licensed Nursing Home Administrator assisted the resident with contacting the Waynesville Police to file an official report. h. The administrator in-serviced all staff including agency staff on the facility policies and procedures regarding Abuse, Neglect, Exploitation and Misappropriation of resident Property. Education started on December 05, 2024. All staff including agency staff will not be allowed to work until the in-service is completed. 2. Identify others that can be affected by the deficient practice and corrective actions taken: All residents have the potential to be affected by the deficient practice. a. The facility interviewed all alert and oriented residents with a Brief Interview of Mental Status (BIMS) score of 11 or greater to determine any other possible misappropriation of resident property.	

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F 602	Continued From page 3 Resident #78 on Saturday, 11/30/24. She stated NA #4 notified her that resident was missing some jewelry. Nurse #1 stated she talked with the resident and then notified the Weekend Supervisor. Resident #78 showed her the 4 cheap costume jewelry rings and told her that someone had taken her rings and replaced them with the cheap rings. Nurse #1 indicated she called the family to verify what rings the resident had. Nurse #1 stated she had never seen the actual rings and had no other knowledge about the missing jewelry. An interview on 12/05/24 at 1:35 PM with the Weekend Supervisor revealed she was notified of Resident #78's missing rings on 11/30/24. The Weekend Supervisor stated the resident told her that she had taken her rings off the night before and placed them in a plastic bag on her bedside table. The Weekend Supervisor stated Resident #78 told her when she got up the next morning (11/30/24), she washed up and when she went to put her rings on, there were other rings in the bag that weren't hers. The Weekend Supervisor notified the Administrator, the police, and the family. She stated she had no idea what happened to them. The Weekend Supervisor recalled the resident got up around 9:30 AM and she talked to the resident between 10 AM and 11 AM. She also stated the resident told her she went to bed on Friday night right after supper between 6 PM and 7 PM. An interview on 12/05/24 at 4:55 PM with the Senior Police Officer revealed he had talked with the resident, her family, and the facility Administrator. He stated he would file a report which would be reviewed by the detectives but there was not much they could do. He stated the	F 602	b. The facility also contacted the family/responsible party of the residents with a Brief Interview of Mental Status score less than 11 to see if they had any knowledge of or concerns regarding missing items or misappropriation of resident property. c. The administrator in-serviced all staff including agency staff on the facility policies and procedures regarding Abuse, Neglect, Exploitation and Misappropriation of resident Property. Education started on December 05, 2024. All staff including agency staff will not be allowed to work until the in-service is completed. 3. Were there any systemic changes necessary to comply with F602? There were no systemic changes as the facility has policies in place regarding misappropriation of resident property. 4. How you plan to monitor through the facility Quality Assurance Performance Improvement program to ensure compliance: The Social Worker or designee will conduct an audit to identify any missing/misappropriated items of all alert and oriented residents and call families/responsible parties of residents with a BIMS score below 11 monthly for three months, quarterly for 9 months, unless deficient practice is found, and the audits will be extended until total compliance is achieved. The monthly audits will be turned in to the Administrator	

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F 602	Continued From page 4 family estimated the cost of the missing rings between $4,000 and $5,000. An interview on 12/05/24 at 10:25 AM with the Administrator revealed she was investigating Resident #78's missing rings and had not yet completed her investigation. Review of the facility investigation report dated 12/06/24 at 3:48 PM documented there were 5 rings missing. These rings were described as white gold bands, one was a diamond cluster, one was a mother's ring with different colored stones across the top, and the others were bands with smaller diamonds. A police report was filed. The allegation was substantiated as the rings were missing but there were no accused employees or individuals.	F 602	to be reviewed in the monthly Quality Assurance meeting to ensure compliance is achieved and maintained. The Administrator is responsible for ensuring complete compliance is achieved. 5. Date of compliance: December 20, 2024	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident,	F 686	Summary of Incident and Findings	12/11/24

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F 686	Continued From page 5 staff, and wound care center Nurse Practitioner (NP) interviews the facility failed to follow physician orders from the wound care center for the treatment of a stage II pressure ulcer (partial thickness open wound) for 1 of 2 residents reviewed for services to prevent and treat pressure ulcers (Resident #233). The findings included: Resident #233 was admitted to the facility on 10/12/23 with diagnoses that included peripheral vascular disease (narrowing of peripheral blood vessels that can cause a disruption in blood flow) with chronic bilateral lower extremity wounds and eczema (a condition that causes red, dry, itchy skin). Resident #233 was discharged from the facility on 6/14/24. The quarterly Minimum Data Set (MDS) assessment dated 4/9/24 revealed Resident #233 was cognitively intact. She was not coded on the MDS for an unhealed pressure ulcer. She was documented on the MDS as having venous and arterial ulcers present. Resident #233 had a care plan dated as initiated on 10/12/23 and revised last on 5/10/24 for potential and actual impaired skin issues related to groin red and chapped, extensive venous stasis wounds to bilateral lower extremities. The care plan goals were for Resident #233's skin to remain intact without signs of breakdown and for her wounds to remain stable without signs of infection through next review. The care plan interventions included to provide wound care as ordered and noted she was followed by the wound care center.	F 686	Resident #233 was seen by an outside wound care provider and received orders for treatment of a stage II pressure ulcer. The facility did not follow the treatment orders from the wound care center; however, the facility was following orders from the facility provider. The facility provider did not discontinue the wound care center order for treatment nor clarify the order with the wound care center. F686 Action Plan 1. Corrective Actions taken for the Resident affected by the deficient practice: The affected resident was discharged from the facility on June 14, 2024. 2. Identify others that can be affected by the deficient practice and corrective actions taken: All residents have the potential to be affected by the deficient practice. a. A chart audit was completed on December 10, 2024, to ensure all orders from outside wound providers were entered in the Electronic Health Record (EHR). b. The Director of Nursing held an in-service with the facility wound care nurse and the unit coordinators on December 11, 2024, to ensure understanding of following/documenting	

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F 686	Continued From page 6 A physician order details page from the wound care center dated 4/12/24 for Resident #233 revealed a pressure ulcer of left lower back, stage II listed under the diagnosis section. Under wound treatment it listed wound #6 to the left posterior back with instructions that read: "cleansing: cleanse with normal saline one time daily; dressing: Optifoam gentle SA (silicone adhesive foam dressing that absorbs drainage and helps evenly disperse pressure) one time daily." Review of Resident #233's treatment administration record (TAR) for April 2024 and May 2024 was reviewed and revealed there were no wound care orders for Resident #233's stage II pressure ulcer on her lower left back. A wound care center progress note dated 4/19/24 by the wound care center Nurse Practitioner (NP) noted on 4/12/24 Resident #233 had complained about a sore on her left lower back, and they had discovered a large stage II pressure ulcer. The note indicated on 4/19/24 stage II pressure ulcer to her left lower back was still present and very painful and Resident #233 had told the wound care center the area had not received care until yesterday. The wound care center note specified the wound needed to be cared for regularly according to the wound care directions. The stage II pressure ulcer was identified in the note as wound #6. The wound was described as open and being in treatment for 1 week. The wound care center note identified the wound classification as a category/ stage II wound with etiology of pressure ulcer located on the left, posterior back. The note provided the measurements and a description of the wound stating it measured 4.5-centimeter (cm) length x	F 686	all wounds orders/treatments whether the order be from our in-house providers or an outside provider. This will include the wound nurse calling the outside provider following the resident's appointment to ensure all orders were received from the provider and entered into the facility's electronic health record. 3. Were there any systemic changes necessary to comply with F686? There are no systemic changes needed as the facility has policies/procedures to follow all orders given from in-house/outside providers. Additional training was held with the wound care nurse to ensure understanding of the facilities policies/procedures of receiving orders from outside providers regarding wound care. 4. How you plan to monitor through the facility Quality Assurance Performance Improvement program to ensure compliance: An audit tool has been developed to monitor outside provider appointments. When an outside wound care appointment has been scheduled it will be noted on the appointment calendar. Using the appointment calendar, chart audits for outside appointments will be completed and documented on the audit tool weekly for one month, every other week for two months, and monthly for three months, unless deficient practice is	

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F 686	Continued From page 7 4.9 cm width x 0.1 cm depth, the wound margin was distinct with the outline attached to the wound base, there was no granulation (new tissue) within the wound bed, and no necrotic (dead/dying tissue) tissue within the wound bed. The progress note indicated the following wound care instructions for the left posterior back wound: primary dressing-foam dressing, adhesive 7x7 three times per week. A physician orders detail page from the wound care center for Resident #233 dated 5/3/24 was present in the electronic medical record and a pressure ulcer of left lower back, stage II was listed under the diagnosis section. Under wound treatment it listed wound #6 to the left posterior back with instructions for an Aquacel foam dressing adhesive (self-adherent foam dressing that decreases bacteria, absorbs drainage, and improves comfort) three times per week. A progress note dated 5/24/24 from the wound care center by the wound care center NP noted the stage II pressure ulcer to Resident #233's left lower back had resolved. A telephone interview was conducted on 12/6/24 at 8:51 AM with the wound care center NP. The NP stated the Stage II pressure injury to Resident #233's left lower back had been identified at the wound care center during her visit on 4/12/24. The NP stated she had classified the wound as a stage II pressure injury and had given wound care orders for the facility to provide wound care. The NP explained she had given orders for a foam dressing to off load and protect the area. The NP recalled when she had seen Resident #233 on 4/19/24 the wound to her left lower back had been painful and Resident #233 had commented	F 686	identified, and the time will be extended until total compliance is achieved. The audit tool will be given to the Administrator monthly to be reviewed in the monthly Quality Assurance meeting to ensure compliance is achieved and maintained. The Director of Nursing is responsible for ensuring all audits are completed and orders are present in the resident's electronic health record. 5. Date of compliance: December 11, 2024	

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F 686	Continued From page 8	F 686		

no one at the facility had provided wound care to the area. The NP said she had made it clear in her notes the wound needed to be cared for every day. The NP further recalled, when Resident #233 had come to the wound care center on 5/3/24 she had not had a dressing in place to the pressure ulcer to her left lower back. The wound care center NP said she put it again in her notes that the wound needed care every day. The wound care center NP said she had seen Resident #233 again on 5/24/24 and the wound had resolved. The wound care center NP explained the wound to Resident #233's lower back could not have been a psoriasis plaque area (raised, red, scaly patch of skin). She explained a psoriasis plaque would have looked different. She recalled Resident #233 sometimes had areas to her arms and face that looked like psoriasis but that the wound to her left lower back was a pressure ulcer and the skin was not dry or flaky. The wound care center NP explained the wound care notes and orders had been faxed to the facility after each visit. She said they were usually faxed to the facility with in 24 hours. She did not recall the facility ever calling the wound care center to ask about Resident #233's wounds, notes, or wound care orders.

A progress note dated 5/8/24 by the Medical Director (MD) said nursing had requested an evaluation of a new left flank skin lesion. The note indicated Resident #233 was followed by outpatient wound care providers for her wounds and at the last visit they had noted a left flank new skin lesion injury. The note said Resident #233 had areas throughout her trunk and had previous psoriatic plaques that had responded well to triamcinolone (a steroid cream) in the past. The note stated Resident #233 had a new Psoriasis

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Plaque to the left posterior trunk with some flaking and that it was not over a bony surface. The note said to initiate triamcinolone.

A telephone interview was conducted with the Medical Director (MD) on 12/6/24 at 10:09 AM. The MD stated she did not remember specifically looking at Resident #233's wounds. The MD explained Resident #233 was followed by the wound care center and deferred to the wound care center for treatment of Resident #233's wounds. The MD said the facility should have followed wound care orders given by the wound care center for all of Resident #233's wounds. The MD thought Resident #233 may have had a reddened area to her back and there was a question about what it was. She did not remember who had asked her to look at the area. She explained she recalled the wound care center had called the area a stage II pressure ulcer, but it was not in a pressure area over a boney area. The MD stated she had ordered triamcinolone cream to the area to see if it healed. The MD said she had felt the area had looked more like Psoriasis.

An interview was conducted with Unit Coordinator #1 on 12/5/24 at 2:49 PM. She explained she had worked as a floor nurse during May 2024. She stated she had cared for Resident #233 during that time and had not recalled Resident #233 having a stage II pressure ulcer to her back. She said she recalled Resident #233 had areas of psoriasis that had been treated with a cream.

An interview was conducted with Nurse #2 on 12/5/24 at 4:44 PM. Nurse #2 did not recall Resident #233 having a pressure ulcer to her left lower back. He said he did not remember her

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F 686	Continued From page 10	F 686		

having any wounds except for the wounds to her legs. He recalled she had a rash to her body and said he thought it had maybe been psoriasis that had been treated with a cream. He did not remember there ever being any wound care orders for a pressure ulcer to Resident #233's left lower back.

An interview was conducted with Nurse #3 on 12/5/24 at 4:45 PM. She explained she had been the wound care nurse but had left that position in February 2024. She stated she now worked at the facility as a floor nurse. Nurse #3 said she had cared for Resident #233, and she did not remember Resident #233 having a stage II pressure ulcer to her left back. She said Resident #233 had eczema and had dry bumpy skin but did not recall her having any wounds other than the wounds to her legs.

An interview was conducted with the Director of Nursing (DON) on 12/5/24 at 3:36 PM. The DON had not recalled Resident #233 having a pressure ulcer to her left lower back. She only recalled Resident #233 having wounds to her legs and areas of eczema while she had been at the facility. The DON reviewed the April 2024 and May 2024 TAR for Resident #233 and verified there were no wound care orders present for a pressure ulcer to her left lower back. The DON explained there had been an issue with the notes from appointments being reviewed for new/updated orders. She explained it had been a facility wide problem she had become aware of in October 2024. The DON further explained, appointment notes had been scanned into the electronic records without first being reviewed for orders, changes, or follow up needs by a nurse. The DON said she thought Resident #233's

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F 686	Continued From page 11 wound care notes/orders had been scanned into the electronic record without first being reviewed for changes or new/ updated orders and that was why the facility had missed the orders and the information about the stage II pressure ulcer to her left lower back. The DON stated the facility had done a complete audit of all appointment notes but had not gone back to look at the notes for residents who had been discharged from the facility. The DON said the orders from the wound care center should have been implemented and followed by the facility, but that facility would not have known what those orders were if no one had reviewed the notes/ orders from the wound care center. An interview was conducted with the Administrator on 12/5/24 at 4:59 PM. The Administrator said the facility had discovered things had been scanned into the electronic chart of residents without being reviewed for orders, follow up needs, or orders being entered not the electronic computer system. The Administrator explained she thought this is what happened and why the wound care orders for Resident #233 had been missed. The Administrator stated the wound care center notes should have been reviewed for orders and the orders should have been implemented and followed by the facility for Resident #233.	F 686		
F 745 SS=G	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 745		12/19/24

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by:
Based on record review, observations, and resident, staff, Physician, Nurse Practitioner (NP), Physician Assistant (PA) and neurology office Scheduler interviews the facility failed to ensure a neurology appointment was scheduled for a resident (Resident #14). The Physician ordered a neurology referral for Resident #14 first on 8/23/24 for evaluation of her tremors. A second neurology consult was ordered by the NP on 11/5/24 again for evaluation of her tremors. Resident #14 had tremors to her upper and lower extremities, including her hands and feet. Resident #14 reported her tremors had worsened, were unmanageable, made her feel awful, and like she could not do anything. Resident #14 reported the tremors made her not want to leave her room because she did not want people to see her in that state. She stated she felt isolated every day and felt down, depressed, and hopeless all the time because nothing was getting better. This occurred for 1 of 1 resident reviewed for medically related social services (Resident #14).

Findings included:

Resident #14 was admitted to the facility on 8/15/24 with diagnoses that included depression, anxiety, mood disorder (depression/ mania), essential tremor (involuntary shaking typically in arms/ hands), drug induced secondary Parkinson's disease (a movement disorder that is caused by medications and causes Parkinson's disease symptoms).

The quarterly Minimum Data Set (MDS) assessment dated 8/16/24 revealed Resident #14 was cognitively intact. She was not documented

Summary of Incident and Findings

The facility did not secure a neurology appointment as ordered for resident #14 on August 18, 2024, and again on November 05, 2024.

F745

Action Plan

1. Corrective Actions taken for the Resident affected by the deficient practice:

a. A follow-up neurology appointment was scheduled on December 05, 2024, for February 20, 2024, at 8:45AM.

2. Identify others that can be affected by the deficient practice and corrective actions taken:

All residents have the potential to be affected by the deficient practice.

a. An audit of all resident charts was completed on December 10, 2024, to ensure all referrals have been scheduled as ordered.
b. The Director of Nursing completed additional training with the transportation coordinator and unit coordinators to ensure understanding of the facility policies/procedures and expectations on scheduling outside appointments. The training included receiving/understanding the orders, facility expectations regarding

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as having behaviors or rejection of care.

A history and physical dated 8/23/24 by the Medical Director (MD) read in part: Patient today is complaining of significant ongoing worsened tremors. She reports she has been evaluated by multiple neurologists in the past however no significant improvement has been made. She reports primidone (a medication used to treat tremors) has been helpful. She was previously on a higher dose. She has trialed Sinemet (a medication used to treat symptoms of Parkinson's such as tremors) with no relief of the symptoms. Reports the tremors are giving her some difficulty completing activity of daily living (ADL) including self-feeding. She does report some ongoing increased mood symptoms. Will refer back to neurology services for further recommendations.

Resident #14's active physician orders revealed an order dated 8/23/24 entered by the Medical Director (MD) that read: Please refer back to neurology for tremor.

Review of Resident #14's electronic medical record revealed there were no records of a neurology appointment being scheduled.

A telephone interview was conducted with the MD on 12/5/24 at 1:21 PM. The MD said Resident #14's neurology appointment should have been scheduled by the facility when she had ordered the referral in August. The MD stated she was not aware a neurology appointment had not been scheduled for Resident #14 after she had given the order for the referral in August. She explained she was not surprised Resident #14 had not been seen yet by neurology because a new patient

timeliness of setting up the appointment/follow-up with the providers if more information is requested and notifying the Director of Nursing to assist if appointment has not been secured within one week of the order being received.

3. Were there any systemic changes necessary to comply with 745?

There are no systemic changes necessary as the facility has policies/procedures regarding following physician orders for referrals. The facility did develop a tracking log to ensure appointments were scheduled in a timely manner.

4. How you plan to monitor through the facility Quality Assurance Performance Improvement program to ensure compliance:

The facility developed an appointment/referral tracking log that will be updated daily by the transportation/assigned appointment scheduler. The referral/appointment tracking log will be reviewed weekly with the Administrator/Director of Nursing to assure the completion of all referrals/appointments. The tracking log will be reviewed weekly for three months and then monthly for three months. The tracking log will be turned in monthly to the Administrator and reviewed with the Interdisciplinary Team as part of the facilities Quality Assurance Performance Improvement meeting for six months and

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referral with neurology could take a long time. The MD indicated it was hard to say 100% if there were any negative effects from Resident #14 being seen later by neurology. She explained she did not know if neurology would make a huge difference but that it was good to get a specialist's opinion because they knew more about it. The MD said she was not sure if neurology would be able to help improve Resident #14's tremors but having a neurologist input was an important part of the puzzle.

A progress note dated 8/27/24 by NP #1 read in part: She [Resident #14] reports her tremors are interfering with her desire to be around others. Patient is anxious and becoming upset as she discusses her tremors.

A psychiatric progress note dated 8/29/24 by PA #1 read in part: She is taking Primidone which interacts with Latuda (antipsychotic medication) and causing extrapyramidal symptoms (EPS) (movement disorders that can occur as a side effect of certain medications), involving significant generalized tremor and muscle twitching. Changes included stopping Latuda, starting Risperidone (antipsychotic medication) 1 milligram (mg) every morning and 2 mg every night for schizoaffective disorder (mental health condition), and starting Benztropine (a medication used to treat movement problems) 0.5 mg every 8 hours as needed (PRN) for tremors/ EPS.

A psychiatric progress note dated 9/5/24 by PA #1 indicated Resident #14 had seen an improvement in EPS since Latuda was switched to Risperidone and PRN Benztropine was added.

A progress note dated 9/13/24 by NP #1 said

extended if complete compliance is not achieved.

The Administrator/Director of Nursing is responsible for ensuring complete compliance is achieved.

5. Date of compliance: December 19, 2024.

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Resident #14 reported shaking in her knees and she had tremors to her bilateral upper extremities and jaw that were tardive dyskinesia (TD) (a movement disorder typically caused by taking certain medications, such as antipsychotic medications) or essential tremors. The note stated, "it is wondered if the shaking in her knee is part of these known tremors."

A progress note dated 9/24/24 by NP #1 read in part: Today her chief complaint is her anxiety and her tremors. She states her tremors are worse today than yesterday. Yesterday her Benztropine was discontinued as her tremors had escalated with the three times daily dosing. She is asking to be placed back on her regimen where it was dosed twice daily, and her tremors were better managed. Today her anxiety seems to be driven by her tremors.

A psychiatric progress note dated 9/26/24 by PA #1 indicated Resident #14 reported her tremors were worse on Benztropine. The note stated she had tremors present primarily to her bilateral upper extremities. The Benztropine was stopped and Artane (a medication used to treat tremors) 1 mg twice daily was added for EPS.

A psychiatric progress note dated 10/11/24 by PA #1 indicated Resident #14 reported some benefit from the Artane but the effects waned midday. Artane orders were changed to 1 mg three times daily for EPS.

A psychiatric progress note dated 10/31/24 by PA #1 indicated the Artane three times daily dosing was reported to have caused an increase in Resident #14's tremors. The note said Resident #14 had been refusing the medication because

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she felt it was causing her tremors to increase. She had also refused her antipsychotic medication. The note revealed Resident #14 denied any return of psychosis symptoms and reported she had only had a single episode of psychosis in her lifetime in the context of grief related to a significant death and questions the validity of the diagnosis. The note revealed Resident #14 no longer wanted to take an antipsychotic medication at all but agreed with allowing the medication to be tapered. Artane was stopped and Risperidone was decreased to 1mg nightly.

A progress note dated 11/5/24 by NP #1 read in part: She is very discouraged today and frustrated by her tremors. She reports she has been evaluated by neurology in the past regarding her tremors and that she was told there was nothing that could done about them. When asking if she would like to have a second opinion regarding her tremors she responded to the affirmative.

Review of Resident #14's active physician orders revealed an order dated 11/5/24 entered by NP #1 read: neurology consult for tremor, make appointment with a [local] neurologist.

A psychiatric progress note dated 11/14/24 by PA #1 read in part: Resident #14 EPS seems worse since stopping both the Artane and Risperidone. She is in some distress over this, feeling frustrated and pessimistic about the future. She is experiencing marked tremulousness in her upper extremities and has been confining herself to her bed most of the time. We discussed treatment options for tardive dyskinesia, and she is receptive to trial of Ingrezza (a medication used to treat tardive dyskinesia). Ingrezza 40 mg daily

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was added for TD.

A psychiatric progress note dated 11/21/24 by PA #1 read in part: Resident #14 presented in a markedly irritable manner today, raising her voice in anger, as she has continued to have symptoms of TD. She has been markedly shaking in her upper extremities, essentially unchanged from when she was last seen and has been spending time in her room much of the time as a result. We discussed the etiology of this, but she was not receptive, and it is not clear to what degree she understood due to her angry state. Changes were made to her medications. Carbidopa-levodopa (a medication used to treat Parkinson's symptoms) 25-100 mg twice daily was added for EPS and Trazodone (a medication used to treat anxiety) 25 mg twice daily was added for anxiety.

An interview was conducted with NP #1 on 12/5/24 at 12:40 PM. She explained the psychiatric PA followed Resident #14 for monitoring and management of her tremors. NP #1 stated she had recently seen Resident #14 and had asked her if she had ever been seen by a neurologist. She recalled Resident #14 told her she had been seen by a neurologist in Waynesville and had been told there was not anything else they could do for her tremors. NP #1 explained Resident #14 had preferred to go see a neurologist in Asheville for a second opinion. NP #1 stated she had made the referral for neurology for Resident #14 because her tremors had not gotten better. She explained several different medications had been trialed for Resident #14 to help with her tremors. NP #1 further explained, some of the medications that were trialed may have made the tremors worse, so those had been stopped and now Resident

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#14's tremors were back to baseline but not getting better. NP #1 said Resident #14's tremors bothered her and affected her quality of life. She said Resident #14 had told her she does like to go to activities much because of her tremors. NP #1 explained Resident #14's tremors did not impact her ability to perform task such as eating but that it was more of a self-image issue and caused her not to want to socialize. She said Resident #14 tremors affects her depression symptoms because of how they affect her life, she explained Resident #14 was followed by psychiatry services to address her psychiatric diagnoses and symptoms. NP #1 stated Resident #1's tremors were not basic essential tremors. She explained there was a psychiatric component to her tremors that needed to be managed by psychiatry and neurology. NP #1 was not aware a neurology referral had previously been made for Resident #14 in August, she said "I just knew she needed to go". NP #1 explained she did not think there was physical harm from Resident #14 being seen later by neurology but that maybe there was emotional harm related to anxiety/ depression being worse. NP #1 stated emotionally it would have been better if Resident #14 would have been seen sooner by neurology for her to have some answers.

A telephone interview was conducted with PA #1 on 12/5/24 at 12:14 PM. He said he followed Resident #14 for psychiatric services. He explained he provided monitoring and management for her tremors. He explained that had been the focus since Resident #14 had been admitted to the facility. PA #1 further explained Resident #14 had been admitted with a diagnosis of schizoaffective disorder. He said her Latuda and Primidone interacted and caused an increase

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in EPS. PA #1 stated he had tried different medications for Resident #14 to manage her tremors but that they did not work. He said Resident #14's tremors had waxed and waned since she had been admitted to the facility. PA #1 said the tremors made Resident #14 anxious and when she was anxious it caused them to worsen. He recalled the last time he had seen Resident #14 she had yelled at him and that was new. He said he had stopped her antipsychotic entirely and she had not had new psychosis. PA #1 said Resident #14's was irritable due to not sleeping well and shaking all the time. He said her tremors sometimes interfered with her sleep and that affected her concentration and mood too. PA #1 explained there were times Resident #14's tremors seemed to get a litter better and then they would get worse again. He said he was unaware of how long or to what degree she was shaking prior to coming to the facility. He said he was aware of the neurology referral and had asked a nurse a couple of weeks ago if there had been a neurology referral put in for Resident #14. He explained at first, he had thought he could manage Resident #14's tremors but when they did not get better, he had thought she would need a neurology referral. He stated he could not remember which nurse he had asked about the neurology referral. PA #1 stated he had not been aware a neurology referral had been made previously for Resident #14 in August. PA #1 said he was not sure if Resident #14's tremors could ever go away but was hopeful they could get to a manageable level where she would be able to hold a cup of coffee. PA #1 explained he thought Resident #14 had drug induced parkinsonian symptoms and a neurologist would be appropriate and beneficial for her. He said Resident #14 had feelings of hopelessness, was

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irritable, and anxious because the tremors were not getting any better.

An interview and observation were conducted with Resident #14 on 12/5/24 at 2:30 PM. Resident #14 was observed in her room, laying on her bed, with the lights off. She was observed to have significant shaking of both her hands and arms at rest and with movement. Shaking was also noted in her legs and feet. Resident #14 said she had tremors before she had been admitted to the facility "but not like this". She explained she now had shaking in her legs and feet. She said her tremors had gotten worse since being at the facility and over the last 3-4 weeks they had become unmanageable. Resident #14 explained different medications had been tried since she had been at the facility to help with her tremors. She said every time her medications were changed "it makes me worse and that makes me feel anxious". Resident #14 stated her tremors made her feel awful and like she could not do anything. She explained they made her not want to leave her room and stated, "I just don't want people to see me in that state". Resident #14 said she felt isolated every day and felt down, depressed, and hopeless all the time because nothing was getting better. Resident #14 was not aware a neurology referral had been ordered for her in August and that no one had come to talk to her about it. She explained she had been seen by a neurologist but that it had been several years since she had been seen. Resident #14 said she would have been okay going to an appointment with same neurologist office if she could have been seen sooner.

An interview was conducted with the facility Scheduler on 12/5/24 at 11:00 AM. The facility

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Scheduler stated if there was an order written for a referral she would fax the appointment referral to the medical office. She explained she would give the office a week or two to call her to schedule the appointment and then if she did not hear from the office, she would call the office to schedule the appointment. The facility Scheduler stated she saved the referrals and 1 to 2 times a month she would sit down and go through the referrals. She explained she would discard the referral if the appointment had been made and would call the office for the ones that had not been scheduled. She stated she did not remember if she had called the neurology office or followed up on the neurology appointment ordered in August for Resident #14 specifically. The facility Scheduler explained she had been working on the floor, helping stock supplies, and had not been at her desk as much to give appointments attention. The facility Scheduler stated she had gotten behind on appointments and had not kept up with them as good as she should have. She explained that the Director of Nursing (DON) and Administrator had talked to her about the appointment process and how it was not working in October. The facility Scheduler stated she needed a new process to keep track of appointments, and she was now using a spread sheet to keep up with appointments. She explained she had faxed the referral for Resident #14 to the neurology office on 8/30/24 and had not heard back from the office to schedule the appointment. She said she did not receive any missed calls or messages from the neurology office regarding scheduling the appointment. The facility Scheduler stated she did not remember if she had called the neurology office to follow up on scheduling the appointment for Resident #14. She said she had

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faxed the neurology referral ordered on 11/5/24 for Resident #14 to the neurologist's office on 11/6/24. She explained she called them on 11/27/24 to follow up on the referral and the office stated they had not received the referral. She stated she had faxed the referral to the office again on 11/27/24. The facility Scheduler said she had called the office this morning and they had scheduled Resident #14 for an appointment on 2/20/25.

A telephone interview was conducted with the neurology office Scheduler at the neurology office on 12/5/24 at 11:00 AM. She stated the neurology referral had been faxed to the office on 8/30/24 by the facility and the office had made multiple attempts to contact the facility to schedule a neurology appointment for Resident #14. She explained the office had called the facility's Scheduler at the number provided on the faxed referral. She provided the number the neurology office had called to attempt to schedule the appointment. The phone number had matched the number present on the faxed referral sheet by the facility that had been confirmed as the correct number by the facility's Scheduler. The neurology office stated they had called and left messages on 9/4/24, 9/11/24, 9/12/24, and 9/16/24 for the facility's Scheduler to call back to schedule an appointment for Resident #14. She stated she knew the dates the office had called and left messages on the phone number provided by the facility, because there were notes about the phone calls, dates, and messages in their system. She explained after the fourth attempt on 9/16/24 the office had closed the referral because they had been unable to reach anyone to schedule the appointment. The neurology office scheduler stated Resident #14 had been an

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	345411	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND TERRACE AND REHABILITATION	516 WALL STREET WAYNESVILLE, NC 28786

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established patient with the office but had not been seen since February of 2022. She explained if the office had called the facility, it was because they had an appointment and could get Resident #14 in to be seen. She said the neurology office booked appointments for about 3-4 months out and that most likely Resident #14 would have been seen in November or December if the facility had followed up on the referral sent on 8/30/24.

An interview was conducted with the DON on 12/5/24 at 3:25 PM. The DON stated Resident #14 should have had a neurology appointment scheduled after the first order had been given in August. She stated the Appointment Scheduler should have talked with Resident #14 to see if she already had a neurologist she had seen previously or what Neurologist she wanted to go to see. The DON said she was not sure what happened and why the appointment was not made. The DON stated the Appointment Scheduler should have followed up with the neurology office if she had not heard back from them in a week. She explained an issue had been noticed in October with appointments not being followed up on and tracked. The DON stated before October there was not a process in place for following up on appointments, tracking appointments/ referrals, or accountability. She stated there had not been a schedule book and appointments had been logged in the Appointment Scheduler's phone. The DON explained the process the facility now had for referrals/ appointments. She said when an order was entered by a provider for a referral the order was pending and had to be confirmed by a nurse. She further, explained when a referral order was confirmed, the order was printed, and given to

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F 745	Continued From page 24 facility Scheduler either by placing it on her desk or putting it in her box. The DON said the referral should be faxed to the office when the facility Scheduler received the referral order. She stated if the facility Scheduler had not heard back from the office within a week about a referral, she should call the office to follow up. She stated the facility Scheduler made a list of appointments for the week and she reviewed them on Fridays and checked them against referral orders on the computer. The DON was not aware the neurology appointment ordered on 11/5/24 had not been scheduled until today. She was not sure why there had been a delay in scheduling the 11/5/24 neurology appointment or why the referral had not been followed up on for 3 weeks. The DON explained Resident #14 needed to go to neurology to have their input on the tremors and hopefully give her some improvement in her quality of life. She said even if going to neurology eased Resident #14's mind then it was worth it. An interview was conducted with the Administrator on 12/5/24 at 5:01 PM. The Administrator stated she was not sure about what happened with the neurology appointment that had been ordered in August or how it had been missed being scheduled. She did not say who had been responsible for appointments when the facility Scheduler had been out. She stated she would expect that if the facility Scheduler had not heard back from the office in a week that she would call the office to see why. The Administrator said there had not been a process for appointments, follow up, or accountability before October 2024.	F 745		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		12/11/24

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F 812	Continued From page 25 §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 observations and staff interviews the facility failed to remove expired nutritional supplement from 1 of 2 nourishment room refrigerators. This practice had the potential to affect residents who received nutritional supplements. Findings included: On 12/4/24 at 2:12 PM an observation of the north nourishment room refrigerator was conducted with the Dietary Manager. The door shelf of the refrigerator contained one container of nutritional supplement dated with 11/25 received date and an additional date of 11/25 open date. The nutritional supplement container was approximately 25% full.	F 812	Summary of Incident and Findings A carton of nutritional supplement was found in the nourishment room refrigerator with a received date of November 25, 2024, and did not have an additional date of when it was opened, therefore it was considered expired from the received date. F812 Action Plan 1. Corrective Actions taken for the Resident affected by the deficient practice:	

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F 812	Continued From page 26 The Dietary Manager stated during the observation that opened and stored refrigerator items should be discarded after 7 days. The Dietary Manager immediately discarded the nutritional supplement. The Dietary Manager stated the nourishment room refrigerator was checked two times daily, once in the morning and once in the evening by the dietary staff for expired items, dated and labeled open items, and items to restock. The Dietary Manager stated the nutritional supplement was placed in the refrigerator by a nurse and was unsure of when it was placed in the refrigerator. The Administrator stated on 12/5/24 at 5:17 PM that open nutritional supplements or opened food items should be disposed of when expired.	F 812	a. All nourishment room refrigerators were inspected on December 11, 2024, by the Housekeeping Supervisor to ensure all items had an open date on the container and there were no items that expired in the refrigerators. b. On December 11, 2024, a sign was placed on the outside of the Nourishment Room refrigerators reminding staff to date anything that has been opened with an open date. c. The Director of Nursing (DON) in-serviced all staff including agency staff on December 11, 2024, that if it is opened, it must have an open date on it and that Med Pass has a seven-day expiration from the opened date. 2. Identify others that can be affected by the deficient practice and corrective actions taken: a. All nourishment room refrigerators were inspected on December 11, 2024, by the Housekeeping Supervisor to ensure all items had an open date on the container and there were no items that expired in the refrigerators. b. On December 11, 2024, a sign was placed on the outside of the Nourishment Room refrigerators reminding staff to date anything that has been opened with an open date. c. The Director of Nursing (DON) in-serviced all staff including agency staff on December 11, 2024, that if it is opened, it must have an open date on it and that Med Pass has a seven-day expiration from the opened date.	

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3. Were there any systemic changes necessary to comply with F812?

The facility has policies in place regarding dating opened containers before storing them. We have implemented a daily audit to be completed by the Housekeeping Supervisor and the Weekend Manager to check all nourishment room refrigerators to assure all containers are labeled with an open date, the refrigerator is within the appropriate temperature range, and there are no expired items in the nourishment room refrigerators. The supervisor will then initial next to the respective date on the log posted on the refrigerator door.

4. How you plan to monitor through the facility Quality Assurance Performance Improvement program to ensure compliance:

Nourishment rooms will be audited daily by the housekeeping supervisor and the weekend manager to ensure all containers are labeled with an open date, the refrigerator is within the appropriate temperature range, and there are no expired items in the nourishment room refrigerators indefinitely. The Housekeeping Supervisor/Weekend Manager will initial next to the respective date on the log posted on the refrigerator door. The log will be turned into the Administrator monthly for six months, unless deficient practice is found, and the time will be extended until total

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F 812	Continued From page 28	F 812	compliance is achieved. The log will be reviewed in the monthly Quality Assurance meeting to ensure complete compliance. The LNHA is responsible for ensuring complete compliance. 5. Date of compliance: December 11, 2024	