STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345102	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maggie Valley Nursing and Rehabilitation	75 Fisher Loop Maggie Valley, NC 28751

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident, staff and Regional Business Office Manager interviews, the facility failed to provide residents with access to their personal trust accounts for more than two months for 2 of 2 residents reviewed for management of personal funds (Resident #74 and #12). This practice had the potential to affect 66 residents who maintained trust accounts at the facility.The findings included:a. Resident #74 was admitted to the facility on [DATE].A review of Resident #74's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact.An interview on 3/19/26 at 8:44 AM with Resident #74 revealed he maintained a trust account at the facility and used his money every month to pay for toiletries and other personal items. He stated facility staff had previously gone to the store monthly to purchase his items and debited his account but reported that staff had not gone to the store for him for the past couple of months and he didn't know why. Resident #74 stated his family had provided his toiletries and other personal items during this period.b. Resident #12 was admitted to the facility on [DATE]. A review of Resident #12's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was moderately cognitively impaired. An interview on 3/19/26 at 9:13 AM with Resident #12 revealed she had routinely received $70 in cash from her trust account at the beginning of every month but had not received any money for over 2 months until 3/17/26 when she received $138 in cash from staff. She reported that she used her money to buy phone minutes for herself and her son. She stated she was still owed $140 and indicated she would have run out of phone minutes the next day if she had not received the money on 3/17/26. On 3/19/26 at 9:26 AM, an interview with the Business Office Manager (BOM) revealed the facility had been purchased by a new company in December 2025 and was in the process of switching bank accounts. She reported the facility had not had a cash box available to give residents money since that time and that no cash was currently available. The BOM indicated Resident #12 had previously received $70 cash at the beginning of each month but had not received any 2026 payments due to the lack of a cash box. She confirmed no residents or responsible parties had received cash for the past two months and that the facility was unable to access resident funds. She revealed she received a call from the Accounts Receivable corporate office on 3/17/26 informing her that $138 in cash was available, and she delivered the money to Resident #12 that same day. The BOM explained that Resident #12 was the only resident to receive cash at the beginning of each month, and reported staff in the Activity Department had previously shopped for residents (including Resident #74), but this was on hold while the trust accounts were inaccessible. On 3/19/26 at 10:27 AM, a phone interview with the Regional Business Office Manager explained that the delay in residents accessing their funds was due to the time needed to transition the facility's financial accounts after the company change. She acknowledged that residents had no access to their funds since January 2026 and was aware that residents should have had access to their funds. She explained there was nothing that could be done until the bank accounts were changed over which should be completed within a week. An interview with the Administrator on 3/19/26 at 2:46 PM confirmed that residents had been unable to access their trust accounts since January 2026. She explained that the unavailability was related to the shift to new bank accounts by the new company. The Administrator noted that residents should have reasonable access to their trust accounts at the facility.

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 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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation after a new serious mental illness disorder was identified for residents previously determined to have a Level I PASRR status for 2 of 4 residents reviewed for PASRR (Residents #8 and #88).The findings included:1. A PASRR Determination Notification letter dated 05/06/13 revealed Resident #8 had a Level I PASRR with no expiration date that indicated no further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or if present, suggests a change in treatment needs for those conditions.Resident #8 admitted to the facility on [DATE] with diagnoses that included major depressive disorder and anxiety disorder.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Her active diagnoses included anxiety disorder and she received antidepressant medication during the MDS assessment look-back period.A Nurse Practitioner (NP) progress note dated 11/19/25 revealed in part, Resident #8 was seen to evaluate nighttime hallucinations after nursing staff reported that Resident #8 was screaming and terrified throughout the night. The NP added Seroquel (antipsychotic) 50 milligrams (mg) every night at bedtime.A psychiatric progress note dated 02/27/26 revealed in part, Resident #8 was seen for a follow-up after her dose of Seroquel was increased to 100 mg on 02/19/26. The psychiatric provider noted that Resident #8 reported decreased hallucinations and mood disturbance since the medication change with the plan to continue the current dose of Seroquel 100 mg every night at bedtime.A North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) inquiry provided by the Regional Social Worker/Discharge Planning Consultant on 03/17/26 at 4:01 PM revealed Resident #8 had a Level I PASRR effective 05/16/13 with no expiration date. There were no PASRR reevaluation requests submitted on or after 11/19/25.During an interview on 03/17/26 at 4:10 PM, the Social Worker (SW) revealed she was responsible for submitting requests for Level II PASRR evaluations, however, she was not always notified when a resident was diagnosed with a new mental illness. The SW stated she did not submit a request for a Level II PASRR evaluation following the new diagnoses of nighttime hallucinations for Resident #8 and it was an oversight.During an interview on 03/19/26 at 2:37 PM, the Administrator stated the SW was responsible for submitting requests for Level II PASRR evaluations per the regulatory guidelines. The Administrator explained the SW was in the process of reviewing and auditing residents' PASRR and felt Resident #8's was just overlooked.2. Resident #88 admitted to the facility on [DATE].A PASRR Determination Notification letter dated 09/19/24 revealed Resident #88 had a Level I PASRR with no expiration date that indicated no further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or if present, suggests a change in treatment needs for those conditions.A psychiatric progress note dated 02/06/25 revealed in part, on 01/30/25 Resident #88 was started on prazosin (medication used to treat high blood pressure and Post-Traumatic Stress Disorder (PTSD) related nightmares) one (1) milligram (mg) every night at bedtime and sertraline (antidepressant) 50 mg daily due to Resident #88's complaints of nightmares and PTSD symptoms. It was noted Resident #88 had diagnoses of PTSD and depression with the plan to continue the current doses of prazosin and sertraline.The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. His active diagnoses included depression (other than bipolar) and PTSD. He received antidepressant medication during the MDS assessment look-back period.A North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manage PASRR requests) inquiry provided by the Regional Social Worker/Discharge Planning Consultant on 03/17/26 at 4:01 PM revealed Resident #88 had a Level I PASRR effective 09/19/24 with no expiration date. There were no PASRR reevaluation requests submitted on or after 01/30/25.During an interview on 03/17/26 at 4:10 PM, the Social Worker (SW) revealed she was responsible for submitting requests for Level II PASRR evaluations, however, she was not always notified when a resident was diagnosed with a new mental illness. The SW stated she did not submit a request for a Level II PASRR evaluation following the new diagnoses of depression and PTSD for Resident #88 and it was an oversight.During an interview on 03/19/26 at 2:37 PM, the Administrator stated the SW was responsible for submitting requests for Level II PASRR evaluations per the regulatory guidelines. The Administrator explained the SW was in the process of reviewing and auditing residents' PASRR and felt Resident #88's was just overlooked.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident who was admitted to the facility with a serious mental health disorder for 1 of 4 residents reviewed for PASRR (Resident #27).Findings included:A PASRR Determination Notification letter dated 12/05/25 revealed Resident #27 had a Level I PASRR with no expiration date.Resident #27 was admitted to the facility on [DATE] with diagnoses that included non-Alzheimer's dementia, anxiety disorder, major depressive disorder, and bipolar disorder.A physician's progress note dated 12/12/25 revealed Resident #27 had a diagnoses of dementia and anxiety with depression that was managed with escitalopram (antidepressant) 10 milligrams (mg) daily, buspirone (antianxiety) 15 mg three times daily, and divalproex sodium (anticonvulsant) 125 mg every morning and 250 mg nightly.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #27's active psychiatric/mood disorder diagnoses included anxiety disorder, depression (other than bipolar) and bipolar disorder. She received antianxiety, antidepressant and anticonvulsant medications during the MDS assessment period. A North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) inquiry provided by the Regional Social Worker/Discharge Planning Consultant on 03/17/26 at 4:01 PM revealed Resident #27 had a Level I PASRR effective 12/05/25 with no expiration date. There were no PASRR requests submitted on or after 12/05/25.During interviews on 03/17/26 at 3:30 PM and 4:01 PM, the Regional Social Worker/Discharge Planning Consultant explained when a resident was admitted with mental health disorders, it should trigger the SW to submit a request for a Level II PASRR evaluation providing the mental health diagnoses were not included on the previous PASRR screening. The Regional Social Worker/Discharge Planning Consultant stated when she reviewed Resident #27's previous PASRR screening, she did not see where Resident #27's mental health diagnoses were included. She confirmed a request for a Level II PASRR evaluation was not submitted and should have been.During an interview on 03/17/26 at 4:10 PM, the Social Worker (SW) revealed she was responsible for submitting requests for Level II PASRR evaluations. She explained she didn't always know when provider notes were scanned into a resident's medical record so she could review but normally, when she realized a resident was admitted with a Level I PASRR and had mental health disorders, she submitted a request for a Level II PASRR evaluation. The SW verified Resident #27 had diagnoses of mental health disorders and a Level I PASRR upon admission. She stated she should have submitted a request for Level II PASRR evaluation but didn't and it was an oversight.During an interview on 03/10/26 at 2:37 PM, the Administrator stated the SW was responsible for submitting requests for Level II PASRR evaluations per the regulatory guidelines. The Administrator explained the SW was in the process of reviewing and auditing residents' PASRR and felt Resident #27's was just overlooked.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews, and staff interviews, the facility failed to implement their infection control policies and procedures when Nursing Assistants (NA) #1, NA #2, and NA #3 did not wear required personal protective equipment (PPE) before entering Resident #79's room who was on special droplet contact precautions. This deficient practice was observed for 3 of 6 staff observed for infection control practices (NA #1, NA #2, and NA #3).Findings included: The facility policy effective 10/24/24 titled Covid-19 read in part that containment/management of a newly identified patient case required the implementation of special droplet contact precautions. Review of Resident #79's Covid-19 test results dated 3/14/26 revealed he had tested positive. Per facility policy he had been placed in special droplet contact precautions isolation and the signage was placed outside his door. The facility special droplet contact precautions signage dated 11/22 instructed staff to perform hand hygiene before entering room, and to wear gown, N95, eye protection (face shield or goggles), and gloves upon entry. An observation on 3/16/26 at 12:52 PM revealed NA #1 and NA #2 entered Resident #79's room wearing surgical masks. The special droplet contact precautions signage was posted outside Resident #79's door. A plastic stackable storage drawer set which held gowns, gloves, N95 masks, and eye protection was observed in the hall outside his door. NA #1 and NA #2 did not perform hand hygiene, and no gown, gloves, eye protection, or N95 mask were observed. NA #1 and NA #2 were observed to physically assist Resident #79 to a sitting position on the side of the bed and set up his lunch tray. They washed their hands with soap and water before exiting the room wearing the surgical masks. An interview on 3/16/26 at 12:54 PM with NA #1 and NA #2 revealed they should have worn gowns, gloves, eye protection, and an N95 mask but they did not and could not explain why. An observation 3/17/26 at 8:55 AM revealed NA #3 inside Resident #79's room wearing a gown, gloves, eye protection, and a surgical mask. No N95 mask was observed. NA #3 was observed to physically reposition Resident #79 in his bed, removed her PPE, and washed her hands with soap and water before exiting the room. An interview on 3/18/26 at 9:29 AM with NA #3 revealed she had been in a hurry to get into Resident #79's room and did not put on an N95 mask. An interview on 3/19/26 at 1:37 PM with the Director of Nursing (DON) stated NA #1 and NA #2 told her they had not read the special droplet contact precaution signage at Resident #79's door and should have. She also stated that NA #3 received education about special droplet contact precautions on 3/16/26 but still had not followed protocol. The DON reported NA #3 stated she put on the wrong mask outside the room. An interview on 3/19/26 at 12:04 PM with the Administrator revealed the staff should have followed the posted special droplet contact precaution signage posted at the resident's door, and she could not explain why they did not.