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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/30/2025 |
| NAME OF PROVIDER OR SUPPLIER Skyland Terrace and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 516 Wall Street Waynesville, NC 28786 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046</p> <p>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).</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on [DATE]. Her diagnoses included: hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] 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.</p> <p>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 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.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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 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.</p> <p>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 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.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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 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. She voiced there had not been any further issues since the supervised visits were put into place.</p> <p>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.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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 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.</p> <p>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.</p> <p>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 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.</p> | | |