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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyland Terrace and Rehabilitation	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to update a care plan to reflect a change of code status for 1 of 18 residents reviewed for care plans (Resident #40).Findings included:Resident #40 was admitted on [DATE] with diagnoses of dementia and epilepsy.Resident #40's care plan was observed on [DATE] and noted as most recently updated on [DATE]. A death with dignity care plan noted Resident #40's wishes included to attempt cardiopulmonary resuscitation (CPR).A progress note written by the Social Worker on [DATE] at 1:27 PM noted Resident #40's family changed the code status to Do Not Resuscitate (DNR).A physician's order for Do Not Resuscitate (DNR) was written on [DATE].Resident #40's comprehensive Minimum Data Set (MDS) dated [DATE] noted he was rarely or never understood.On [DATE] at 2:28 PM during an interview, the SW stated that any new or updated code status forms which were completed would be placed into the physician's notebook for their review and signature. The physician would also write an order for the code status in the resident's chart. The SW confirmed Resident #40's code status was changed from Full Code to DNR on [DATE]. She indicated she did not recall if she had informed the MDS nurses of the change in code status or if it had been discussed in the morning meeting after the order had been written.On [DATE] at 3:45 PM an interview was conducted with MDS Nurse #1 and MDS Nurse #2. Both MDS Nurses stated they were responsible for making updates to the care plans including any code status changes. MDS Nurse #1 stated care plans were reviewed quarterly during the resident's care plan meeting. MDS Nurse #1 explained she was not aware Resident #40's code status had been changed. Both MDS Nurses said they relied on information reported during the morning meeting for any change of orders or resident conditions. They stated they did not recall Resident #40's code status change had been reported. During an interview on [DATE] at 3:16 PM the Administrator stated Resident #40's current code status should be reflected on the care plan. The Administrator explained the care plan should have been updated when Resident #40's code status was changed.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a record review and staff interviews, the facility failed to have a nurse assess a resident who had fallen prior to moving the resident for 1 of 2 residents reviewed for falls (Resident #34). Findings included:Resident #34 was admitted on [DATE] with diagnoses of dementia and heart failure.Resident # 34's annual Minimum Data Set (MDS) dated [DATE] coded her with severe cognitive impairment. She required moderate assistance for transfers. She was coded for having behaviors and falls since her last MDS assessment.Resident #34 was care planned on 1/28/26 for participation in restorative care due to being at risk for falls during transfers and demonstrating poor safety awareness. The care plan included providing moderate assistance during all transfers as an intervention to promote safety. Furthermore, the resident was care planned for a history of physical aggression towards others on 12/1/25. Interventions included to remove the resident from any situation that may be escalating or causing agitation and to assess and anticipate the resident's needs for food, thirst, toileting needs, comfort level, body positioning and pain.A progress note written by Nurse #3 on 2/18/26 at 7:42 AM was reviewed. The note stated that Nurse Aide (NA) #1 notified Nurse #3 that while assisting Resident #34 with dressing and transferring, the resident became combative. NA #1 reported that she had to lower Resident #34 to the floor during the transfer for safety. Upon assessment, Nurse #3 noted no visible deformities and identified a skin tear on the resident's right forearm. Resident #34 reported pain in the right arm. The wound was cleansed, and bandages were applied. Vital signs were obtained and were within normal limits. The provider, Director of Nursing (DON), and the resident's family were notified.NA #1 was interviewed on 2/19/26 at 12:05 PM via phone and confirmed she worked from 11:00 PM on 2/17/26 until 7:00 AM on 2/18/26 (3rd shift). She stated on 2/18/26 she was ending her shift, and she went into Resident #34's room to provide care and dress Resident #34 for the day. NA #1 said she explained to Resident #34 what she was going to do with her. NA #1 said she was able to provide incontinent care with no aggression from the resident. The NA then assisted the resident to the edge of the bed and moved the wheelchair close to the bed in preparation to transfer the resident. She transferred Resident #34 bear hug style while not touching the resident's arms. As NA #1 was lifting the resident from the bed, the resident began to be aggressive with hitting and yelling and NA #1 lowered the resident to the fall mat beside the bed. NA #1 stated she called for help and went to the door of the room and asked NA #2 for help. NA #2 and the NA #3 went into the room and transferred the resident from the fall mat into her wheelchair. NA #1 stated once NA #2 and NA #3 entered the room, she had no further interaction with Resident #34 and let NA #2 handle the incident.NA #2 was interviewed on 2/19/26 at 12:35 PM via phone. The NA stated that on 2/18/26 around 6:45 AM, NA #1 was asking for help outside Resident #34's room. NA #1 told her Resident #34 was hitting her when she was trying to transfer the resident and she had to lower the resident onto the floor. NA #2 and NA #3 went into Resident #34's room and found her sitting on the fall mat with her back against the bed. NA #2 said the resident did not complain of any pain while on the fall mat. NA #3 helped her pick the resident from the mat and place her in the wheelchair. The NA then removed the resident's night gown and found a large skin tear to her right forearm. NA #2 stated she went to get Nurse #3 to look at the skin tear. Furthermore, NA #2 reported that NA #1 told her Resident #34 had been lowered onto the fall mat and that she did not consider this to be a fall. NA #2 stated this was the reason she did not notify the nurse to assess Resident #34 before moving her off the fall mat.On 2/19/26 at 3:29 PM, NA #3 was interviewed via phone. She was with NA #2 on 2/18/26 around 6:45 AM when NA #1 came out of Resident #34's room asking for help. NA #3 stated it was her first shift working at the facility and NA #2 was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	training her. NA #1 said the resident was fighting her during transfer and she had to set the resident on floor. NA #2 and NA #3 went into Resident #34's room and found the resident sitting on the floor with her back against the bed. NA #3 stated she and NA #2 picked up the resident from the floor and placed her in the wheelchair. Resident #34 was rubbing her right arm while in the chair and then they removed the resident's night gown that revealed a large skin tear to the resident's right forearm. NA #2 then left the room to get Nurse #3 to assess and treat the skin tear. Nurse #3 was unavailable for interview.On 2/18/26 at 4:11 PM the Unit Coordinator was interviewed. She stated Resident #34's incident happened around 6:45 AM on 2/18/26. The Unit Coordinator was informed by Nurse #3, that Resident #34 had a skin tear after NA #1 had to set her on the floor during a transfer. The Unit Coordinator went to Resident #34's room and measured the skin tear. It measured approximately 6.5 centimeters in length.The Administrator was interviewed on 2/19/26 at 2:24 PM. She stated when Resident #34 was lowered to the floor, it was considered a fall. The NAs should have notified the nurse to assess the resident for any injuries before the resident was moved.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to administer a pneumococcal vaccine to a resident who had consented to receive the vaccine for 1 of 5 residents reviewed for pneumococcal vaccines (Resident #72).Findings included:Resident #72 was admitted to the facility on [DATE].The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #72 had severe cognitive impairment.Review of Resident #72's medical record revealed no documentation that staff had administered a pneumococcal vaccine. The prior pneumococcal immunization history documented revealed a history of Prevnar 13 (pneumococcal 13-valent conjugate) dated 2/11/16.Review of Resident #72's medical record revealed a form titled 'Vaccine Consent Form 2025'. The pneumonia vaccine was marked under the section titled Individual Requests the Following Vaccination(s). The vaccine consent signature section showed that Resident #72's Responsible Party signed the consent for the pneumococcal vaccine on 9/03/25. An interview on 2/17/26 at 11:16 AM with the Director of Nursing (DON) who also served as the Infection Preventionist for the facility. She stated she assessed and administered immunizations for all new admissions and ensured all residents received vaccines and were up to date per Centers for Disease Control and Prevention (CDC) Guidelines. She stated that the current CDC guidelines recommend pneumococcal conjugate vaccine 20 (PCV20) for residents to be up to date. She explained that she used a CDC algorithm with the resident's prior vaccines to help her determine when a resident needed a vaccine to stay up to date. She entered Resident #72's prior vaccines and stated that the resident should have had the PCV20 to be up to date. She was unable to say why this had not been done. An interview on 2/91/26 at 10:06 AM with the Administrator stated she expected resident vaccines to be kept up to date, and she did not know why staff had not administered the PCV20 vaccine Resident #72.