STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. Building B. Wing	10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swannanoa Valley Health and Rehabilitation	1984 US Highway 70 Swannanoa, NC 28778

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with staff and residents, the facility failed to ensure a resident's accessibility to the light switch that was located behind the bed for 1 out 1 resident reviewed for accommodation of needs (Resident #44). The findings included: Resident #44 was admitted to the facility on [DATE] with diagnoses of spinal stenosis. The 7/19/25 quarterly Minimum Data Set (MDS) assessment revealed that Resident #44 was cognitively intact. She had no impairment of her upper or lower extremities and used a wheelchair for mobility. During an observation on 9/29/25 at 11:50 AM the light switch for the over bed light fixture was located behind Resident #44's bed. There was a pull string/cord that was attached with a broken string that was approximately 10 inches long. It was 3 1/2 feet from the floor and 3 feet from the bed. Resident #44 was unable to reach the string/cord from her bed to turn the light on/off when needed. An interview was conducted with Resident #44 on 9/29/25 at 11:55 AM. Resident #44 stated that she had back pain often and so she stayed in her bed much of the time. When asked about the light switch behind her bed Resident #44 stated she would like to use it but couldn't reach it. Resident #44 stated that she had forgotten about the light because the cord had been broken for a long time and could not remember if she had notified the staff when it was first broken. On 10/1/25 at 9:39 AM a follow up interview was conducted with Resident #44. Resident #44 was lying in her bed reading and the room was dimly lit. The light behind the bed was off. Resident #44 was asked if she would like the light on and she stated yes. The light was turned on and she said, that is much better. Resident #44 was again asked if she would like to be able to turn the light on and off herself and she stated she would. On 10/1/25 at 10:00 AM an interview was held with the Maintenance Director. He stated that he and other maintenance staff went around the facility and fixed the light switch cords on a weekly basis because they often broke. The Maintenance Director could not say when or if the light cord for Resident #44's was fixed at the last go around. The Maintenance Director looked at Resident #44's light switch and agreed it needed an extension added to the cord so that Resident #44 could turn the light on/off. On 10/2/25 at 1:05 PM an interview was held with the Director of Nursing (DON) and she stated that any resident that would like to be able to use the pull cord for the light switch should be able to reach it. On 10/2/25 at 2:01 AM an interview was held with the Administrator. She stated that she would expect Resident #44 to have her pull cord available to her but also stated that Resident #44 was able to communicate to staff if she wanted her light on.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with residents, pharmacy, medical director, nurse practitioner and staff, the facility failed to implement an effective system to ensure the antidiarrheal medication was reordered and available to administer which resulted in 12 missed doses for 1 out of 1 resident reviewed for pharmacy services (Resident #4) The findings included: Resident #4 was admitted to the facility on [DATE] with diagnoses of incontinence, end stage renal disease and end stage renal dialysis. The 8/28/25 quarterly Minimum Data Set (MDS) revealed that Resident #4 was cognitively intact. He had a urinary catheter and was always incontinent of bowel. There was a physician order with a start date of 3/18/25 for medication diphenoxylate-atropine (Lomotil)-controlled drug 2.5-0.025 milligrams (MG). Resident #4 was to get 2 tablets four (4) times a day for diarrhea. The September 2025 Medication Administration Record (MAR) showed that Resident #4 was receiving his diphenoxylate-atropine four times a day at 2:00 AM, 8:00 AM, 2:00 PM and 8:00 PM up until 9/27/25. On 9/27/25 starting with 2:00 AM dose it was recorded that the dose was put on hold. On 9/27/25, 9/28/25 and 9/29/25 each of the 4 doses were recorded either on hold or see nurses note. On 9/30/25 the medication was coded to have been given as ordered. On 10/1/25 at 2:44 PM an interview was held with Medication Aide #2. She stated she worked on 9/26/25 and 9/27/25 from 7:00 PM till 7:00 AM. On 9/27/25 she went to administer the 2:00 AM lomotil medication to Resident #4's and saw that he was out of the medication. Medication Aide #2 reported this to the [NAME] Side Unit Manager. The [NAME] Side Unit Manager told her that she would take care of it. On 10/2/25 at 11:13 AM an interview was conducted with Nurse #4. She stated that she worked on 9/27/25 from 7:00AM until 7:00 PM and when she looked over her medication cart, she noticed that Resident #4 did not have any of his lomotil medication. Medication Aide #2, whose shift was now ending and was giving the keys to the cart to Nurse #4, did not have any information on what was going on with the medication but stated the Medical Director might coming around to do rounds and to ask him about it. Nurse #4 stated that the Medical Director never did come in to do rounds. Nurse #4 said that during her shift she changed Resident #4's dressing and his wound looked good, and he was not experiencing any diarrhea. On 10/1/25 at 3:13 PM an interview was held with the [NAME] Side Unit Manager. She stated that every Friday the facility had a team meeting to go over medications and for the staff to check their medication carts to ensure they have everything needed for the weekend, especially controlled medications. She stated that on the weekend the on call providers get really upset if they are asked to order a controlled medication. So, the facility tries hard not to make this type of call to the weekend on call provider. She stated they had the medication cart meeting on 9/26/25 and the agency nurse who had the west side cart did not report that the lomotil for Resident #4 was low and needed a new order. On Saturday 9/27/24 the [NAME] Side Unit Manager stopped by the facility and when she was at the facility Medication Aide #2 alerted her that there was no more lomotil for Resident #4. The unit manager told Medication Aide #2 that one of the nurses needed to call it in. The Unit Manager also stated she would take care of it and was unsure how she left the conversation for the nurse to take care of it or herself. On 10/2/25 at 9:18 AM an interview was conducted with Nurse #3. Nurse #3 stated she worked the 7:00 AM to 7:00 PM shift on 9/28/25. Nurse #3 stated when she started her shift, she was informed at report that Resident #4's lomotil medication was out. Nurse #3 stated that later that day the west side Unit Manager stopped by and asked if any medications or narcotics needed to be called into the pharmacy and Nurse #3 informed the Unit Manager that Resident #4 needed his lomotil medication. The Unit Manager stated she had already been informed about that medication and that it should be coming in from the pharmacy. During the interview Nurse #3 stated that a nurse can reorder a medication through eMAR but not a narcotic. For a narcotic the nurse would enter the need for a new script in the Nurse Practitioner (NP) book or peel off the medication label on the empty pack and put that in the NP book alerting the NP that it needed to be reordered. Nurse #3 did check Resident #4's skin and spoke to Resident #4 and he knew that he was out of the one medication. Resident #4 was not experiencing diarrhea. On 10/2/25 at 1:17 PM a telephone call was made to the East Side Unit Manager but was unsuccessful. On 10/1/25 at 2:04 PM an interview was held with Medication Aide #1. Medication Aide #1 worked the weekends from 7:00 PM until 7:00 AM. She stated that she worked on Resident #4's hall passing medication on 9/28/25. When she started her shift, she had been informed by a nurse, she could not remember who, that Resident #4 was out of his lomotil medication. Medication Aide #1 stated the nurse told her that the pharmacy had been called to deliver the medication, but by the end of the

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to remove expired food (walk in cooler #1) and failed to remove perishable food with grey and white fuzz (walk in cooler #2) from 2 out of 2 walk in coolers. This practice had the potential to affect food served to residents. The findings included: a. On 9/29/25 at 10:02 AM an initial tour of the kitchen was conducted with the Dietary Manager (DM). During the initial tour it was observed in the walk in cooler #1 four (4) containers (32 ounces each) of vanilla low fat yogurt that were unopened and had a best if used by date of August 26, 2025. There was also one gallon size container of cottage cheese that was opened, and half of the product was gone with a best if used by date of August 24, 2025. b. On 9/29/25 at 10:02 AM an initial tour of the kitchen was conducted with the DM. In the walk in cooler #2 an observation was made of one container of fresh strawberries. The container had 2 strawberries covered in grey and white fuzz. On 9/29/25 at 10:15 AM an interview was held with the DM. The DM stated that the expired food in both walk in coolers was a visual oversight. The DM stated that it was her responsibility to check the coolers for expired food and she normally checked the entire kitchen for expired food every morning. The DM also stated she had worked at the facility for one month and was training her team to also be checking the dates of all the food before serving and/or getting food out of a container. On 10/2/25 at 1:57 PM an interview was held with the Administrator. The Administrator expected that the kitchen staff would be looking at the dates and getting rid of food as needed especially if past the use by date and/or had signs of spoilage.

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record reviews, and staff interviews, the facility failed to implement their infection control hand hygiene policy when the Wound Nurse failed to change gloves and perform hand hygiene after wound care for Resident #30 and Resident #18. This occurred for 1 of 5 staff members observed for infection control practices (Wound Nurse). Findings included: A review of the facility's Hand Hygiene Policy revised 01/01/25 revealed hand hygiene should be completed before donning gloves and immediately after gloves were removed.1a. A continuous observation of wound care for Resident #30 was completed with Wound Nurse Practitioner and Wound Nurse on 10/01/25 from 9:11 AM through 9:25 AM. Resident #30 had a sign on her door which instructed staff to don gloves and a gown for high contact resident care activities which included wound care. Personal protective equipment (PPE) was observed on Resident #30's door. The Wound Nurse Practitioner and Wound Nurse performed hand hygiene and donned gown and gloves. Resident #30 was positioned for wound care and the Wound Nurse Practitioner cleaned and assessed Resident #30's wound to buttocks. The Wound Nurse Practitioner removed gloves and gown, performed hand hygiene, and exited the room. The Wound Nurse then applied calcium alginate (an absorbent dressing), ointment to the wound area and applied a bordered dressing. The Wound Nurse failed to remove gloves which were visibly soiled with ointment. Resident #30 stated she had a new reddened area to her right heel. The Wound Nurse assessed Resident #30's right heel area, and still wearing the same gloves, went to door, grabbed the doorknob and opened the door and asked the Wound Nurse Practitioner for skin prep. The Wound Nurse then applied skin prep to Resident #30's right heel reddened area without changing gloves and performing hand hygiene directly after she performed wound care to the buttocks wound. The Wound Nurse failed to remove her gloves, then rolled absorbent pad under Resident #30 out and replaced the pad underneath Resident #30. The Wound Nurse failed to remove her gloves and then applied Resident #30's socks, opened the closet door, and obtained heel protectors from the closet and applied heel protectors to Resident #30 feet. The Wound Nurse failed to remove gloves and replaced the sheets and blankets on Resident #30 bed and raised the head of the bed when she pressed buttons on the foot of the bed. The Wound Nurse then grabbed the call bell, placed it within reach of Resident #30, and turned off the overhead light by pulling the string, and pushed the bedside table next to the bed without removing her gloves. The Wound Nurse then removed gloves and gown and performed hand hygiene before she exited the room. 1b. A continuous observation of wound care for Resident #18 was completed on 10/01/25 at 11:51 AM through 12:26 PM. Resident #18 had a sign for Enhanced Barrier Precautions (EBP) (type of isolation) on the room door which instructed staff to don gloves and a gown for high contact resident care activities which included wound care. PPE was observed on Resident #18's door. The Wound Nurse performed hand hygiene and donned a gown and gloves. Resident #18 was positioned for wound care and the Wound Nurse cleaned Resident #18's wound to right hip with gauze, applied skin prep, and prepared packing gauze strip for use. The Wound Nurse pulled her gown up and began touching her scrub pockets with the gloved hands and reached into her pockets and verbalized she was looking for her scissors. The Wound Nurse stated the scissors were left on her treatment cart and removed her gown and gloves and performed hand hygiene before exiting the room. The Wound Nurse retrieved scissors from the treatment cart and reentered the room. The Wound Nurse performed hand hygiene, donned a new gown and gloves, and began packing the right hip wound while holding the scissors in her hand. The Wound Nurse covered Resident #18's right hip wound with a bordered dressing. The Wound Nurse removed gloves and performed hand hygiene. The Wound Nurse applied new gloves and Resident #18 was positioned for wound care to his buttocks. The Wound Nurse cleaned Resident #18's buttocks wound with gauze, applied skin prep, packed buttock wound with gauze strip, cut the gauze strip, and applied a bordered dressing over buttocks wound. The Wound Nurse failed to remove gloves and perform hand hygiene after wound care to buttock wound and grabbed Resident #18's walker to move it closer to him. The Wound Nurse failed to remove gloves or perform hand hygiene and assisted Resident #18 to a standing position, retied her gown, and pulled Resident #18's pants up and buttoned them. The Wound Nurse then discarded trash, removed her gloves and gown and discarded PPE. The Wound Nurse performed hand hygiene before she exited the room. An interview with the Infection Preventionist (IP) was conducted on 10/01/25 at 3:46 PM. She stated the Wound Nurse should have changed gloves after wound care was provided to prevent contaminating surfaces.An interview with Wound Nurse was conducted on 10/01/25 at 12:09 PM. The Wound Nurse verbalized understanding that