STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 12/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, family interview and staff interviews, the facility failed to notify an interested family member about changes in	F 157	Smoky Mountain Heath and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies	1/20/14

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

Electronically Signed | 01/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 12/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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
F 157	Continued From page 1 condition for 1 of 12 sampled residents. Resident #5's family was not notified when she was placed in isolation and was prescribed and administered an antibiotic, intravenous therapy, and a new anti-anxiety medication. The findings included: The policy Notification of Changes dated 1/2009 included in part: The facility will inform the resident;consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status or the need to alter treatment or to commence a new treatment. Resident #5 was admitted to the facility originally on 11/29/06. The medical record included an Admission Record Face Sheet for the current admission date of 11/29/06 that listed a family member as the emergency contact and having financial responsibility. Resident #5's diagnoses included an intestinal infection, encephalopathy, dehydration, psychosis, urinary tract infection, pneumonia, dysphagia, Parkinson's disease, hypothyroidism. peripheral vascular disease, hypertension and depression. The medical record failed to include evidence that the emergency contact family member (here after referred to as family) was contacted with changes in condition as follows: A. Nursing notes dated 10/28/13 at 2:33 PM revealed a stool specimen was collected for	F 157	and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Smoky Mountain Health and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Smoky Mountain Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F0157 Resident #5's chart was reviewed by the Social Services Director on 12/30/13 to verify contact information is correct. Resident #5's Health Care Power of Attorney (HCPOA) was notified by nursing staff (LPN) on 12/30/13 of residents' readmission to the facility. The Social Services Director verified and updated phone numbers and addresses on all current residents from the HCPOA, Responsible Party (RP) and/or the emergency contact on 1/6/14. Upon admission, the Social Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 12/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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
F 157	Continued From page 2 testing. Nursing notes dated 10/28/13 at 7:01 PM revealed Resident #5 was confined to her room this day. Nursing notes dated 10/29/13 at 1:28 AM stated Resident #5's test revealed she had Clostridium difficile (c-diff) infection and was started on an antibiotic and put on contact isolation at this time. Nursing notes dated 10/30/13 at 6:44 AM stated Resident #5 was very upset about having to stay in her room and she was crying and saying she did not want to live if she had to stay in her room. The nursing notes did not include any notification of family regarding the infection, isolation or administration of an antibiotic. Nurse #1 who documented the lab results and orders for contact isolation and the antibiotic for c-diff stated during a phone interview on 12/23/13 at 6:10 PM that she did not call family about the change in condition because of the late hour and notified the oncoming nurse. She further stated Resident #5 was already on isolation. Nurse #2, who followed Nurse #1 on 10/30/13, stated during a phone interview on 12/23/13 at 4:53 PM that she had called the family many times with changes in condition and would have called about the new antibiotic and isolation. She further stated she should have documented the notification in the medical record. Telephone interview with the family on 12/23/13 at 5:20 PM revealed she was unaware Resident #5 was placed in contact isolation in October. She was told about the time in November but not October. A quarterly Minimum Data Set dated 11/04/13 coded Resident #5 with intact cognition, having	F 157	Director verifies with the family the specific type of information they wish to be contacted on and documents this information, which is accessible to nursing staff. Residents that are their own responsible party or congnitively intact are asked by nursing if family should be contacted of any changes. All residents that have a HCPOA will automatically be contacted by nursing of any changes. Licensed nurses were 100% in-serviced on 12/24/13 by DON and/or QI Nurse on notifying HCPOA, RP, and/or emergency contact on all changes concerning the residents such as new laboratory orders, behaviors, medication/treatment changes, incidents and/or accidents, and any significant changes in resident condition. The QI Nurse and/or DON will audit 5 charts weekly X 1 month for responsible party, legal representative, and/or emergency contact notification of changes/additions in condition, medication, treatments, behaviors, and incidents/accidents. The QI Nurse and/or DON will then audit 5 charts twice monthly X 1 month, and then monthly X 3 months. Any discrepancies will be addressed at the time found with correction and re-education by the QI Nurse and/or DON. The QI Nurse and/or DON will report the audit results to the weekly QA/QI Committee which consists of MDS Nurses, QI Nurse, DON, and Administrator. The QI Nurse will report audit results to Executive QA/QI Committee during the quarterly meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 12/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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
F 157	Continued From page 3 no delirium and no behaviors, requiring extensive assistance with all activities of daily livings skills except eating and being unsteady with balance. Resident #5 was retested for c-diff on 11/11/13 and she completed her antibiotic treatment on 11/12/13. On 11/13/13 the test returned negative and she was removed from contact isolation. B. Nursing notes dated 11/19/13 at 10:44 PM revealed that she was noted with diarrhea and a stool specimen was obtained for lab testing in the morning. Nursing notes dated 11/20/13 at 4:11 PM revealed Resident #5 once again tested positive for c-diff and orders were obtained to place her back on contact isolation and another antibiotic was ordered. There were no notes indicating that the family was notified of the new infection, resumed isolation and/or the new antibiotic. Nurse #3 who obtained the stool specimen and received the orders for the new infection stated during interview on 12/23/13 at 3:25 PM that the family should be notified for any new medication orders including a antibiotic. Nurse #3 could not specifically recall if she called the family concerning the change in condition and that communication with the family should have been documented. C. Nursing notes dated 11/22/13 at 8:34 AM revealed Resident #5 was "shaking perfusely (sic) and crying; cannot speak clearly; extremely anxious; not making any sense; dropped drink on herself; tryed (sic) to put glasses in her mouth; had her upper dentures in the top on her mouth. M.D. notified and Ativan (an anti-anxiety medication) ordered for pts (patient's) anxiety."	F 157	which consists of the Medical Director, DON, Pharmacy Consultants, MDS Nurses, and Administrator to identify potential trends and frequency of continued monitoring, as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 12/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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
F 157	Continued From page 4	F 157		

Another nursing note date 11/22/13 at 3:13 PM revealed Resident #5 was trying to get out of her chair, and was extremely agitated. The nurse practitioner was notified and Ativan was again ordered as needed every 6 hours for 72 hours. There was no documentation noting that the family was notified of the behavior changes or the new anti-anxiety medication order.

Interview on 12/23/13 at 3:03 PM with Nurse #4, who wrote both entries in the 11/22/13 nursing notes, revealed she notified families for any incident, change of medication, change of behaviors and would document the notification in the nursing notes. She further stated she could not recall if she called the family for Resident #5.

Nursing notes revealed that Resident #5 was hospitalized on 11/23/13 and returned to the facility on 11/25/13.

A telephone interview with the family on 12/23/13 at 5:20 PM revealed she was not informed about the administration of Ativan until Resident #5 was hospitalized. She was informed by the hospital staff.

D. Nursing notes dated 12/01/13 at 11:08 PM revealed Resident #5 again tested positive for c-diff and was started on another antibiotic. Nursing notes dated 12/02/13 at 10:37 AM, written by Nurse #2 revealed Resident #5 was very confused, picking at the air, crying at intervals and talking to someone who was not present. The note stated she asked a nurse aide to bring her a knife to kill herself. The next nursing note dated 12/02/13 at 10:59 AM stated a housekeeper came to the nurse and stated that the nurse aide had ben told by the resident that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 12/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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
F 157	Continued From page 5	F 157		

she needed a knife to kill herself and this nurse (Nurse #4) contacted the social worker. The notes were silent to family notification.

Interview with Nurse #2 on 12/23/13 at 4:53 PM revealed she would document family notification in the nursing notes.

Interview with Nurse #4 on 12/23/13 at 3:03 PM revealed she did not call the emergency contact regarding the 12/02/13 threat to kill herself. She told the social worker who would have called the family.

Interview with the Social Worker (SW) on 12/23/13 at 3:08 PM revealed the SW spoke to the resident on 12/02/13 and offered to arrange to have her talk to someone about her feelings. The SW stated Resident #5 denied that she would hurt herself. The SW could not recall if she spoke to the family about this incident or not.

Interview with the family on 12/23/13 at 5:20 PM revealed the SW had informed the family that Resident #5 was acting out but did not share with the family Resident #5's threats to hurt herself. She further stated the conversation with the SW occurred after the 12/03/13 hospitalization.

E. On 12/02/13 at 6:00 PM, the physician ordered hydration via intravenous (IV) with lab testing and discontinued 2 diuretics. This was noted as infusing in the nursing notes dated 12/02/13 at 10:50 PM by Nurse #5. The IV was noted in the nursing notes along with Resident #5 being confused and picking at the air on 12/03/13 at 12:58 AM by Nurse #1, and on 12/03/13 at 1:44 PM by Nurse #2. On 12/03/13 at 12:45 PM the family was noted in the facility and requested

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 12/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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
F 157	Continued From page 6	F 157		

a particular hospital she wanted Resident #5 to be sent.

Interview with Nurse #6 on 12/23/13 at 1:00 PM revealed that documentation of notification to families should be documented in the progress notes. She further stated that the floor nurses would do the notification.

Interview with Nurse #5 on 12/23/13 at 3:34 PM revealed notification to families should be made of any major change or hospitalization. She stated Nurse #6 actually started the IV after she was unsuccessful at starting it. She further stated she called the family and left a message that they started an IV due to dehydration. Because Nurse #5 saw an improvement, she did not call the family back when the family failed to return the call from the facility.

Nurse #2 stated on 12/23/13 at 4:53 PM that she did not call the family about the IV because she was not on duty when it was initiated.

Interview with the family on 12/23/13 at 5:20 PM revealed she discovered Resident #5 had an IV infusing when she arrived at the facility on 12/03/13. She stated that was when Nurse #6 informed the family that Resident #5 was deteriorating.

Interview with the Director of Nursing (DON) on 12/23/13 at 4:22 PM revealed that notification of family should be done immediately for any time there was a change including behaviors, new medication, and significant changes in a resident. She further stated that the family notification should be documented in the progress notes. DON stated there should have been family

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 12/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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
F 157	Continued From page 7 notification when there was a change in stool, a new order for an antibiotic, a new order for Ativan, the insertion of an IV, and the resident wanting to kill herself. Interview with the Administrator on 12/23/13 at 6:15 PM revealed he expected notification to be made for changes in condition, hospitalizations, room changes but not necessarily for medication changes. He stated those with power of attorney should be notified but not necessarily an emergency contact person. He further stated that Resident #5's family was not considered by him to be an interested family member, further giving the example of her not participating in care conferences.	F 157		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, family interview and staff interview, the facility failed to provide evidence of an investigation and follow up of a grievance for 1 of 1 sampled resident. (Resident #5). The findings included: Review of the Grievance Resolution policy dated 2/2009 revealed: The Administrator was responsible for investigating grievances in a	F 166	F0166 Resident #5's HCPOA had meeting on 1/7/14 with MDS Nurses, DON, Social Services Director, and Speech Therapist to discuss resident's care in depth, expectations, notifications, disease process and diet. A 30 day review for all grievances reviewed on 1/6/14 during monthly QA/QI	1/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 12/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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
F 166	Continued From page 8 prompt manner. The Administrator was to assure that the resident or family members were notified timely of the results of the investigation and of any corrective measures taken. The policy continued stating that concerns or grievances from a resident/family member were to be committed to writing using the facility's Resident Concern Record. A Resident Concern Log was to be completed and was to be reviewed by the Quality Improvement Committee on a periodic basis. If the resident and/or family member believed that the concern was not adequately addressed, they could contact the Corporate Office. Resident #5 was admitted to the facility originally on 11/29/06. The medical record included an Admission Record Face Sheet for the current admission date of 11/29/06 that listed a family member as the emergency contact and having financial responsibility. Resident #5's diagnoses included an intestinal infection, encephalopathy, dehydration, psychosis, urinary tract infection, pneumonia, dysphagia, Parkinson's disease, hypothyroidism. peripheral vascular disease, hypertension and depression. On 12/02/13 at 6:00 PM, the physician ordered hydration via intravenous (IV) with lab testing and discontinued 2 diuretics. This was noted as infusing in the nursing notes dated 12/02/13 at 10:50 PM by Nurse #5. The IV was noted in the nursing notes along with Resident #5 being confused and picking at the air on 12/03/13 at 12:58 AM by Nurse #1, and on 12/03/13 at 1:44 PM by Nurse #2. On 12/03/13 at 12:45 PM the emergency contact was noted in the facility and	F 166	meeting. MDS Nurses, Administrator, DON, Medical Director, and QI Nurse present. Administrator was 100% in serviced on 12/24/13 on initiating and completing grievances by the Social Services Director. All grievances will be documented in writing on a Resident Concern form by licensed nurses, Administrator, Social Services Director, or DON and forwarded to appropriate department managers. All grievances will be investigated and concluded in 72 hours with family notified of results of investigation by Social Services Director. All grievances will be forwarded to the Social Services Director and will maintain a monthly log and ensure proper follow up. The monthly grievance log will be audited monthly by Social Services Director and will report any discrepancies immediately to the Administrator. The QI Nurse will report results from monthly grievance log to the monthly QA/QI Committee which consists of the Medical Director, DON, MDS Nurses, and Administrator for review and the identification of potential trends.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 12/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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
F 166	Continued From page 9	F 166		

requested a particular hospital she wanted Resident #5 to be sent.

Interview with Nurse #6 on 12/23/13 at 1:00 PM revealed that documentation of notification to families should be documented in the progress notes. She further stated that the floor nurses would do the notification.

Interview with Nurse #5 on 12/23/13 at 3:34 PM revealed notification to families should be made of any major change or hospitalization. She stated Nurse #6 actually started the IV after she was unsuccessful at starting it. She further stated she called the family and left a message that they started an IV due to dehydration. Because Nurse #5 saw an improvement, she did not call the family back when the family failed to call the facility.

Nurse #2 sated on 12/23/13 at 4:17 PM that she did not call the emergency contact about the IV because she was not on duty when it was initiated.

Interview with the emergency family contact on 12/23/13 at 5:20 PM revealed she discovered Resident #5 had an IV infusing when she arrived at the facility on 12/03/13. She stated that was when Nurse #6 informed the family that Resident #5 was deteriorating. The emergency family contact stated the nurse told her that Resident #5 "went south" which was upsetting to her. She stated she informed the Administrator about the terminology that was used and about a bruise on her lower leg. The Administrator agreed to look into her concerns.

Review of the grievance log revealed nothing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 12/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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
F 166	Continued From page 10 regarding Resident #5 and the family's concerns about dignity, notification of the IV or of an unknown bruise. Interview with the Administrator on 12/23/13 at 6:15 PM revealed Resident #5's emergency contact family approached him after Resident # 5 was hospitalized on 12/03/13. Per the Administrator, the emergency contact family member was unhappy that she was not contacted about the change in Resident #5's condition, including a new intravenous (IV) administered for dehydration. He stated the family was screaming about her concerns. The Administrator also stated the family was questioning a fall and burn area on the resident's ankle. The Administrator stated that he did not feel writing the concern down as an official grievance was necessary as it was after the fact and he admitted to not being good at documenting. He stated that his findings included that staff said they called and left a message about the IV and the spot on the ankle was not noticed until on the way to the hospital. The Administrator stated that he had not called the family back to discuss his findings. He further stated he normally has other staff follow up with grievances and families.	F 166		