STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345305	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY RIDGE HEALTH & REHABILITATION	310 PENSACOLA ROAD BURNSVILLE, NC 28714

(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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 residents (Resident #78) identified as PASRR Level II. Findings included: Resident #78 was admitted to the facility on 10/18/18 with diagnoses including: anxiety disorder, depression, insomnia, and post-traumatic stress disorder (PTSD). A review of the medical record revealed a Level II PASRR completed on 10/17/18 prior to Resident #78's admission to the facility on 10/18/18. A review of Resident #78's Significant Change MDS assessment, dated 10/25/18, indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review were used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care. An interview was conducted, on 11/15/18 at 09:45 AM, with the Admissions Coordinator. She stated	F 641	(1)Facility designee failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 residents. Resident # 78 identified as a level II PASRR. Facility Admissions Coordinator/ designee obtained correct documentation supporting resident #78 from applicant look up and letter of determination all-inclusive via NCMUST.COM for Level II PASRR. Resident # 78 MDS was reviewed and updated 11/15/18. RN MDS Coordinator resubmitted correction of Resident #78 Significant Change MDS for 10/25/18 to reflect the correct coding of PASRR Level II for Resident #78. Resident #78□s care plan reflects PASRR Level II. (2)All residents have the potential to be affected. All new admissions will be screened for accurate PASRR levels. A review of all active resident charts were audited by Admissions Coordinator/designee 11/15/18 including applicant look up and confirming letters of determination all-inclusive from NCMUST.COM. All residents reviewed revealed correct PASRR levels specific to their indicated level of care. All residents with PASRR level II are located in each	12/14/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/12/2018

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F 641	Continued From page 1 that she never saw an original PASRR letter but looked at the North Carolina Medicaid Uniform Screening Program (NCMUST) website and determined Resident #78's PASRR level. An interview was conducted on, 11/15/18 at 09:50 AM, with the Licensed Practical Nurse (LPN) MDS Coordinator. She stated that the Significant change MDS on 10/25/18 for Resident #78 should have been coded as a Level II PASRR. An interview was conducted on, 11/15/18 at 10:09 AM, with the LPN MDS Coordinator. She indicated that she never saw the original PASRR letter. During the interview, she called the North Carolina Medicaid Division of Health Benefits and indicated that she received a clarification which revealed that Resident #78 was a PASRR Level II. An interview was conducted on, 11/15/18 at 10:27 AM, with the director of nursing (DON). She indicated that her expectation was that the Significant change MDS, dated 10/25/18, should have been coded as a PASRR Level II. An interview as conducted, on 11/15/18 at 10:31 AM, with the Administrator. She stated that her expectation was that the Significant change MDS, dated 10/25/18, should have been coded for PASRR level II. On 11/15/18, at 03:05 PM, the Registered Nurse (RN) MDS Coordinator stated that she submitted a correction to the Significant Change MDS dated 10/25/18 to reflect Resident #78 was PASRR Level II.	F 641	individuals chart as well as Admissions office. All residents will be reviewed at the time of admission and then a routine audit completed to reapply for PASRR to prevent lapse. (3)Licensed Nursing Home Administrator began immediate in servicing to Admissions Coordinator and designees 11/15/18 relating to the procedure and expectation for obtaining and maintain correct information or PASRR levels upon admission and reviews. PASRR should include applicant look up and letter of determination all-inclusive via NCMUST.COM. Education completed 11/15/18. Admissions Coordinator/MDS coordinator/Designee will complete audit of PASRR Levels to ensure correct documentation represents accurate PASRR Level of the medical record. Results of the audit will be taken to QAPI meeting to evaluate compliance. Admissions Coordinator/MDS designee will complete audit of PASRR Levels and renewals 5x a week x 4 weeks, then weekly x 4 weeks then monthly x 3. Obtainment of PASRR Levels will be completed for each potential admission prior to arrival for verification of PASRR Level to ensure continuing compliance. (4)Admissions Coordinator/MDS/designee will complete audit of PASRR Levels and renewals as well as correct PASRR level coding on the MDS 5x a week x 4 weeks, then weekly x 4 weeks then monthly x 3. Results of these reviews will be taken to the QAPI Committee meeting monthly to	

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F 641	Continued From page 2	F 641	ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. The Admissions Coordinator/designee is responsible for overall compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		12/14/18

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F 656	Continued From page 3 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 residents (Resident #78) identified as PASRR Level II. Findings included: Resident #78 was admitted to the facility on 10/18/18 with diagnoses including: anxiety disorder, depression, insomnia, and post-traumatic stress disorder (PTSD). A review of the medical record revealed a Level II PASRR completed on 10/17/18 prior to Resident #78's admission to the facility on 10/18/18. A review of the Significant Change Minimum Data Set (MDS), dated 10/25/18, indicated Resident #78 received antianxiety and antidepressant medication during the 7-day look back assessment period. A review of the Care Area Assessment (CAA)	F 656	(1)Facility MDS/designee failed to develop a care plan to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 residents. Resident # 78 identified as a level II PASRR. Facility Admissions Coordinator obtained correct documentation supporting resident #78 Level II PASRR. Resident # 78 MDS reviewed and care plan updated 11/15/18. RN MDS Coordinator resubmitted correction of Resident #78 Significant Change MDS for 10/25/18 to reflect the correct coding of PASRR Level II for Resident #78. Resident #78□s care plan reflects PASRR Level II. (2)All residents have the potential to be affected. A review of all active resident charts were audited by Admissions Coordinator 11/15/18. Care plans for those with PASRR Level II were reviewed and updated by MDS coordinator. All residents reviewed, revealed correct PASRR levels specific to their indicated	

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F 656	Continued From page 4 associated with the Significant Change MDS, dated 10/25/18, indicated Resident #78 received the following psychotropic medications: Cymbalta for depression, Trazodone for insomnia, Buspar for anxiety, and Klonopin for anxiety daily and that a care plan was developed. A review of Resident #78's care plan, last reviewed on 10/31/18, revealed there was a care plan for psychotropic medication use but no care plan was developed for PASRR Level II. On 11/15/18, at 10:09 AM, an interview was conducted with the Licensed Practical Nurse MDS Coordinator. She stated that that the MDS Coordinator completed the care plans and the PASRR Level II should have been on the care plan (CP). On 11/15/18, at 10:27 AM, an interview was conducted with the Director of Nursing (DON). She indicated that her expectation was that the CP should have indicated a PASRR Level II. On 11/15/18, at 10:31 AM, an interview was conducted with the administrator. She indicated that her expectation was that the PASRR Level II CP should have been developed.	F 656	level of care. All residents with PASRR level II have care plans reflecting PASRR Level II. All residents will be reviewed at the time of admission by completing applicant look up and letter of determination all in-inclusive via NCMUST.COM and MDS notified of PASRR Levels to establish care plans specific to PASRR Level. (3)Licensed Nursing Home Administrator began immediate in servicing to Admissions Coordinator, MDS coordinators (who are responsible for care plan development) and designees 11/15/18 relating to the procedure and expectation for obtaining and maintain correct information of PASRR levels upon admission and reviews. Education completed 11/15/18. Admissions Coordinator/Designee will complete audit of PASRR Levels to ensure correct documentation represents accurate PASRR Level in the medical record and a copy of PASRR Level given to MDS Coordinator. Results of the audit will be taken to QAPI meeting to evaluate compliance. MDS Coordinator/designee will complete audit of PASRR Level II care plans 5x a week x 4 weeks, then weekly x 4 weeks then monthly x 3. Obtainment of PASRR Levels will be completed for each potential admission prior to arrival for verification of PASRR Level to ensure continued compliance. (4)MDS Coordinator/designee will complete audit of PASRR Levels II care plans 5x a week x 4 weeks, then weekly x	

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F 656	Continued From page 5	F 656	4 weeks then monthly x 3. Results of these reviews will be taken to the QAPI Committee meeting monthly to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. The MDS Coordinator/designee is responsible for overall compliance.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow a physician's order to document daily body checks 5 out of 5 months in nurses' notes for 1 of 1 resident who received an anticoagulant medication (Resident 20). Findings included: Resident #20 admitted to the facility on 10/13/15 with diagnoses that included atrial fibrillation (irregular heartbeat) and personal history of transient ischemic attack (brief stroke-like attack) and cerebral infarction (caused by a blockage or narrowing of the arteries supplying blood and oxygen to the brain) with residual deficits.	F 658	(1)The facility failed to follow a physician□s order to document daily body checks in nurse□s notes for 1 of 1 residents, resident #20. Staff Development coordinator began in-servicing on 11/15/18 to all licensed nursing staff to ensure compliance with policy and expectations of body audit completion as it relates to documentation and accuracy of medical records are met. Individual education was provided to wound care nurse as it relates to documentation of residents order for daily body audits with documentation in the nurses notes 11/15/18. Resident #20 body audit was completed by wound care nurse on 11/15/18 and documented in the nurses notes. Clarification order was	12/14/18

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F 658	Continued From page 6 Review of Resident #20's physician orders summaries for the months of July 2018 to November 2018 revealed an order which read, "body check daily on 7:00 AM to 3:00 PM shift, complete and document in nurses' notes (started 07/28/18)." Review of Resident #20's Medication Administration Records (MAR) and Treatment Administration Records (TAR) for the months of July 2018 to November 2018 revealed daily body checks were initialed as being completed daily. Review of the nurses' notes for the period 07/28/18 to 11/13/18 revealed entries documenting skin conditions dated 08/01/18, 08/07/18, 08/08/18, 08/09/18, 08/10/18, 08/12/18, 08/19/18, 08/20/18, 08/21/18, 08/30/18, 09/01/18, 09/08/18, 09/16/18, 09/17/18, 09/18/18, 09/29/18, 10/06/18, 10/07/18, and 11/07/18. Review of Resident #20's medical record revealed two undated and blank body audit forms. There was no evidence body audit forms were completed for the months of July 2018 to November 2018. Review of the quarterly Minimum Data Set (MDS) dated 08/24/18 revealed Resident #20 had moderate impairment in cognition and was impaired on both sides of upper extremities. Further review revealed Resident #20 received an anticoagulant medication (blood thinner) daily	F 658	written 11/16/18 to discontinue daily body audits and document in nurses notes to resume weekly body audits and document findings on body assessment form. (2)All residents have the potential to be affected. A review of body audits from the last 30 days regarding weekly skin checks completed to ensure nursing documentation is present. Licensed nursing staff will be responsible for completion of body audits as assigned. Wound care nurse will complete daily audits to ensure nursing staff are completing assigned audits. (3)DON/ADON & SDC began immediate in-servicing on 11/15/18 and educations were completed on 11/27/18 for licensed nursing staff related to the procedure and expectation regarding body audit documentation is met. Wound care nurse/Designee will complete audit of weekly body audits to ensure nursing documentation reflects accuracy of body evaluation form. Results of the audit will be taken to QAPI meeting to evaluate compliance. DON/designee will complete audit of weekly body audits 5x a week x 4 weeks, weekly x 4 weeks then monthly x 3. Each licensed nursing staff hired after this date will be provided with a signed education regarding policy and expectation related to clinical documentation and accuracy of the body evaluation form to ensure compliance. (4)DON/designee will complete audit of weekly body audit assignment 5x a week	

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F 658	Continued From page 7 during the 7-day assessment period. Observation of Resident #20 made on 11/14/18 at 9:32 AM revealed dark bruising on the top of her left hand. Observation of Resident #20 made on 11/15/18 at 8:45 AM revealed a round circular faded bruise (approximately the size of a dime) on the inside of her left upper arm and dark bruising on the top of her left hand. During an interview on 11/15/18 at 11:15 AM Nurse #1 revealed nurses and Wound Care Nurse (WCN) checked Resident #20's skin daily. Nurse #1 explained they only document in nurses' notes when abnormalities or new bruising was noticed. During an interview on 11/15/18 at 2:50 PM the WCN confirmed she completed body audits on all residents in the building which included a head-to-toe assessment. The WCN explained when completing the body audit, she focused on the "bony and peri-areas" to see if there were any skin breakdown or bruising and then initialed the resident's TAR to indicate the audit was completed. The WCN added she only documented in nurses' notes if there was anything abnormal noticed. During an interview on 11/15/18 at 3:57 PM the Assistant Director of Nursing (ADON) stated she expected for nursing staff to check residents' skin	F 658	x 4 weeks, weekly x 4 weeks then monthly x 3, for potential documentation that may be required. Results of these reviews will be taken to the QAPI Committee meeting monthly to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. The DON/ADON is responsible for overall compliance.	

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F 658	Continued From page 8 daily and if there was anything abnormal noticed she would expect there to be a corresponding nurse note. The ADON reviewed the physician's order dated 07/28/18 for Resident #20 and confirmed there should be a daily nurse note indicating a skin audit was completed. She reviewed Resident #20's medical record and confirmed the nurses' notes did not include daily entries as indicated on the physician order and there were no completed body audit forms. The ADON was unable to explain why documentation was not done as ordered and stated it was her expectation a body audit form was completed weekly. During an interview on 11/16/18 at 2:02 PM the Director of Nursing (DON) confirmed Resident #20 had an order for daily body audits to be completed and documented. She stated it was her expectation for body audits to be completed at least weekly and documented on a body audit form. The DON added that although body audits were completed for Resident #20, nursing staff did not follow the physician's order to document.	F 658		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		12/14/18

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F 812	Continued From page 9 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard an open undated milk carton and failed to ensure a nutritional supplement was not stored beyond expiration for 1 of 1 nourishment room refrigerators. The findings included: On 11/16/18, at 12:30 PM, an observation was made of the nourishment room #1 and refrigerator #1 that revealed an 8-ounce (oz) (237) milliliter (mL) carton of whole milk was opened, undated, and without a resident's name. The dietary manager (DM) indicated that a nursing assistant should have discarded the carton. Further observation, of the nourishment room #1 and refrigerator #1, revealed 1 of 1 cans of Nepro with Carb Steady Therapeutic Nutrition 8 fluid oz (237 mL) supplement was found. The Nepro can indicated that the use by date was June 1, 2018. The DM stated that he did order the Nepro supplements. Dietary manager further stated that the evening shift dietary aids checked the nourishment rooms and refrigerators at 12:00 PM every day. He	F 812	(1)The facility failed to discard an open undated milk carton and failed to ensure a nutritional supplement was not stored beyond expiration for 1 of 1 nourishment room refrigerators. The carton of open undated milk and expired nutritional supplement were discarded immediately. Staff Development coordinator began in-servicing 11/16/18 to all staff to ensure compliance with policy and expectations related to storage of supplements are met. (2)All residents have the potential to be affected. An audit of both nourishment refrigerators were completed revealing no other identified issues. Dietary manager/designee will complete daily audit checks for both nourishment kitchen refrigerators to ensure compliance with proper storage of supplements are met. (3)DON/ADON & SDC began immediate in-servicing on 11/16/18 and educations were completed on 11/27/18 for staff related to the procedure and expectation regarding proper storage of supplements are met. There is to be no storage of open	

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SMOKY RIDGE HEALTH & REHABILITATION	310 PENSACOLA ROAD BURNSVILLE, NC 28714

(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 812	Continued From page 10 indicated that someone must have opened the milk carton and did not throw the carton away. He further indicated that dietary aids only checked the food, milk, and Med Pass liquid. He revealed that central supply stocked the Nepro supplement. An interview was conducted with the Central Supply staff member at 11/16/18 at 02:00 PM. She indicated that she stocked Boost, Nepro, and Ensure supplements. She further indicated that she tried to check the supplements in the nourishment room refrigerator and cabinets once a week. She stated that when the month ends, and the new month was approaching, she pulled out any expired supplements from the nourishment rooms. She further stated that she did not know how the expired supplement slipped by but that she just overlooked it. She revealed there was no policy on checking expiration for supplements and there were no logs which documented checking the expiration dates. An interview was conducted on 11/16/18 at 02:05 PM with the Director of Nursing (DON). The DON revealed that the Central Supply staff person checked the nourishment rooms weekly and she overlooked the expired Nepro. The DON stated that her expectation was that the milk and the Nepro should have been discarded. An interview was conducted with the Administrator on 11/16/18 at 02:10 PM. She stated that her expectation was that the nourishment rooms and refrigerators not have any expired products or opened containers without labeling them with the date.	F 812	supplements without name and date. There is to be no expired supplements in nourishment room. Dietary Manager/designee will complete daily audits of nourishment room and refrigerators. Results of the audit will be taken to QAPI meetings to evaluate compliance. Dietary Manager/designee will complete audit of nourishment kitchen refrigerators 5x a week x 4 weeks, weekly x 4 weeks then monthly x 3 to ensure compliance. (4)Dietary Manager/designee will complete audit of nourishment kitchen refrigerators 5x a week x 4 weeks, weekly x 4 weeks then monthly x 3, for potential incorrect storage issues. Results of these reviews will be taken to the QAPI Committee meeting monthly to ensure ongoing substantial compliance. The results of compliance will be reviewed every month x 3 months at the monthly QAPI meeting, then quarterly at QAPI meeting until resolved. The Dietary Manager/designee is responsible for overall compliance.	