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 _____	R-C 01/28/2020

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 000	INITIAL COMMENTS An onsite revisit was conducted on 01/28/20. Tags F-641 and F-690 were corrected as of 01/28/20. Repeat tags were also cited. The facility remains out of compliance. Event ID #TB0U12.	F 000		
{F 584} SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	{F 584}		2/14/20

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

Electronically Signed | 02/18/2020

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{F 584}	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure resident geriatric chairs were clean and free of dried spills for 3 of 3 geriatric chairs (Residents #10, #11, and #12) and also failed to properly label personal care equipment for 1 of 5 bathrooms (bathroom 306) that were reviewed for environmental conditions. Findings included: 1. An observation of Resident #10's geriatric chair on 01/28/20 at 9:37 AM revealed dried liquid stains to the left side of the chair and debris to the right side of the chair. An observation of Resident #11's geriatric chair on 01/28/20 at 9:38 AM revealed dried stains to both sides of the geriatric chair. An observation of Resident #12's geriatric chair on 01/28/20 at 9:39 AM revealed a large amount of dried material on the left side of the chair. An interview with the Director of Nursing (DON) on 01/28/20 at 2:48 PM revealed geriatric chairs should be cleaned when visibly soiled. The DON stated third shift cleaned geriatric chairs weekly	{F 584}	(1)The facility failed to ensure resident geriatric chairs were clean and free of dried spills for 3 of 3 geriatric chairs (Residents #10, #11, and #12) and also failed to properly label personal care equipment for 1 of 5 bathrooms (bathroom 306) that were reviewed for environmental conditions. Geriatric chairs for residents # 10, #11, and #12 were immediately taken and power washed and cleaned to ensure chairs were clean and free of dried spills 1/28/20. Resident bathroom 306 was reviewed and all personal items labeled 1/28/2020. Staff Development coordinator began in-servicing again on 1/28/2020 to all staff to ensure compliance with policy and expectations related to proper housekeeping were met; related to interventions applied to provide a safe, clean, comfortable, homelike environment. Facility department head room rounds were reviewed and expectations reiterated. Room rounds resumed and increased to daily checks 7x week to ensure compliance. (2)All residents have the potential to be	

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{F 584}	Continued From page 2 and they were last cleaned 01/23/20. Staff who cleaned the geriatric chairs on 01/23/20 were unavailable for interview during the investigation. An interview with the Administrator on 01/28/20 at 3:20 PM revealed geriatric chairs should be cleaned weekly as scheduled and when visibly soiled. 2. An observation of the bathroom of room 306 on 01/28/20 at 2:19 PM, which was shared by two residents who resided in the room, revealed an unlabeled denture cup and unlabeled bottle of roll-on deodorant sitting on the side of the sink. An interview with the housekeeper assigned to 300 hall on 01/28/20 at 2:20 PM revealed he checked resident bathrooms for unlabeled items when he cleaned them. He stated he cleaned the bathroom of room 306 earlier on 01/28/20 and did not notice any unlabeled personal items in the bathroom at that time. An interview with a nurse aide (NA) #1 on 01/28/20 at 2:30 PM revealed she was the NA for 300 hall. She stated there was no process for checking for unlabeled items in shared bathrooms. The NA stated she did not know who the denture cup and deodorant belonged to. An interview with the Director of Nursing (DON) on 01/28/20 at 2:48 PM revealed the personal items in the shared bathroom of room 306 should have been labeled and she was not sure why they were not. She stated administrative staff had been checking the rooms and bathrooms for unlabeled personal items and she was not sure	{F 584}	affected. A review of facility rounds, housekeeping rounds and deep cleansing schedule reviewed and revised as indicated. Housekeeping Supervisor will audit all room rounds and deep cleaning schedules to ensure compliance established. Department heads assigned room rounds to ensure expectations for a safe, clean, comfortable, homelike environment are met. This includes but is not limited to labeling of personal items and observation of wheel and geriatric chairs for soiling or debris. Items identified are to be corrected when observed. DON/designee will collect weekly room rounds from department head room round assignments. (3)DON/ADON & SDC began immediate in-servicing on 1/28/2020 and educations were completed on 2/14/2020 for all staff related to the procedure and expectation to maintain safe, clean, comfortable homelike environment are met. Room rounds will be completed daily 7x week until compliance is established. Wheel and geriatric chairs will be observed 7 x week by department heads and spot cleaned as need and deep cleaned weekly per third shift nightly assignment or as otherwise assigned to hospitality aide. Results of the audit will be taken to QAPI meeting to evaluate compliance. DON/designee will collect audit of room rounds and deep cleaning reports at end of each week, 7x a week for 30 days, then 5x week for 30 days, then 2x week ongoing thereafter until substantial compliance is established. Each facility staff member hired after this date will be	

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{F 584}	Continued From page 3 when room 306 was last checked. A joint interview with the Administrator and DON on 01/28/20 at 5:06 PM revealed the Administrator expected personal items to be labeled. The DON stated room 306 had last been checked for unlabeled personal items on 01/24/20.	{F 584}	provided with a signed education regarding policy and expectation related to facility cleaning and follow through to reflect safe, clean, comfortable, homelike environment to ensure compliance. (4)DON/designee will collect audit of room rounds and deep cleaning reports,7x a week for 30 days, then 5x week for 30 days,then 2x week ongoing thereafter until substantial compliance is established for potential interventions and 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 Administrator (LNHA) is responsible for overall compliance. Date of completion 02/14/2020.	
{F 761} SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	{F 761}		2/14/20

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{F 761}	Continued From page 4 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to date an opened multi-use bottle of tuberculin purified protein derivative (PPD) that was available for use in 1 of 2 medication refrigerators observed for medication storage. Findings included: An observation of the North unit medication room refrigerator on 01/28/20 at 2:11 PM revealed an opened but undated multi-use 1 milliliter (ml) bottle of tuberculin PPD solution. An interview with Nurse #1, who was the Unit Manager of the facility's North unit, on 01/28/20 at 2:11 PM revealed the 1ml bottle of PPD solution should have been dated when it was opened. She stated the PPD solution was probably opened on 01/24/20 because there were 5 residents admitted that day. Nurse #1 stated because there was no date as to when the vial of PPD solution was opened the PPD solution would have to be discarded. An interview with the Director of Nursing (DON)	{F 761}	(1)The facility failed to date an opened multi-use bottle of tuberculin purified protein derivative (PPD) that was available for use in 1 of 2 medication refrigerators observed for medication storage. The PPD vial was immediately discarded in appropriate receptacle and removed from use. Pharmacy requisition notes that the PPD Tubersol 5T units/0.1ml was delivered 1/16/20 at 420pm. An audit completed by DON/ADON revealed medication room audit completed 1/24/20 with no identified issues as it relates to dated vials when opened. Staff Development Nurse Educator began in-servicing to nursing staff 1/28/20 and completed 2/14/20 to ensure compliance with policy and expectations were met; related to labeling and storage of medications policy and procedure. Both medication storage rooms were re-evaluated to ensure compliance. (2)All residents receiving PPD injections have the potential to be adversely	

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{F 761}	Continued From page 5 on 01/28/20 at 2:48 PM revealed the PPD solution should have been dated when it was opened. She stated the refrigerator was last checked for undated medications on 01/24/20 and none were found at that time. The DON stated the nursing staff failed to date the PPD solution when it was opened even after receiving recent in-service education on the facility policy of dating medications when they were opened. An interview with the Administrator on 01/28/20 at 3:20 PM revealed she expected the nurse who opened the PPD solution to have dated the medication at the time it was opened. She stated staff had been educated multiple times about following the facility policy of dating medications when they were opened.	{F 761}	affected. A review of medication storage rooms were re-evaluated to ensure compliance met with labeling and storage of medications. Audits will now be 7x a week until substantial compliance is met. (3)DON/ADON & SDC began immediate in-servicing on 1/28/20 and 100% of educations completed on 2/14/20 for licensed nursing staff related to labeling and storage of medications policy and procedure. DON/Designee will audit medication storage locations. Results of the audit will be taken to QAPI meeting to evaluate compliance. DON/designee will complete audit 5x a week x 4 weeks, 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 labeling and storage of medications to ensure compliance. (4)DON/Designee will audit medications rooms for labeling and storage of medications 5x a week x 4 weeks, weekly x 4 weeks then monthly x 3, for potential interventions and documentation that may be required. Results of these reviews will be taken to the QAPI Committee meeting by DON/designee 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. Date of completion 02/14/2020.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		2/14/20

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F 867	Continued From page 6 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the recertification/complaint survey of 12/05/19. This was for one deficiency that was originally cited in December 2019 and subsequently recited on the current follow-up and complaint survey of 01/28/20. The re-cited deficiency was in the area of labeling and storage of drugs and biologicals. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F-761 Label/store drugs and biologicals: Based on observations and staff interviews the facility failed to date an opened multi-use bottle of tuberculin purified protein derivative (PPD) that was available for use in 1 of 2 medication refrigerators observed for medication storage. During the recertification and complaint survey of 12/05/19 the facility was cited for failing to date an opened multi-use bottle of tuberculin purified	F 867	The Administrator was educated by the Regional Director of Operations on the facilities Quality Assurance Performance Improvement program (QAPI) on 2/04/2020. The education included identifying areas of continuous quality monitoring and the tools to be used. The Administrator educated facility staff on 02/12/2020 regarding the policy and procedures on the QAPI program. Education also included monitoring activities, a focus on the processes that effect resident outcomes and performance improvement. Ongoing monitoring will be used to re-establish the facilities outcomes. Administrator is accountable for the overall implementation and functioning of the QAPI program. The QAPI committee will meet monthly to continue to monitor and identify areas of improvement to include survey deficiencies. The Committee will address the identified needs through improvement, action plans and monitoring the effectiveness of such plans. The Regional Director of Operations (RDO) will review the facility QAPI Committee meeting minutes for up to six months to ensure ongoing compliance.	

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F 867	Continued From page 7 protein derivative (PPD) that was available for use in 1 of 2 medication refrigerators observed for medication storage. An interview with the Administrator on 01/28/20 at 5:06 PM revealed the medication storage refrigerators were last checked on 01/24/20 for undated medications and the undated medications would probably have been caught by staff on 01/28/20 or 01/29/20.	F 867	Date of completion 02/14/2020.	