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 _____	C 08/01/2017

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

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F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interviews, the facility failed to document	F 514	Nurse assigned to resident #1 & #4 failed to document verbal altercation resulting in	8/29/17

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

Electronically Signed | 08/07/2017

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.

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F 514	Continued From page 1 an altercation in the medical records for 2 of 3 sampled residents who had incidents that required staff intervention. Residents #1 and #4 were involved in a resident to resident altercation which resulted in a room change and the incident was not documented in either resident's medical record. The findings included: 1. Resident #1 was admitted to the facility on 07/03/17 with diagnoses including anxiety disorder, psychosis, and dementia. The admission Minimum Data Set dated 07/12/17 coded him as having intact cognition and having no moods or behaviors. He was coded as being independent with bed mobility, transfers and locomotion. Behavior charting revealed he began having behaviors on 07/12/17 during which time he notified 911 of wanting an electric wheelchair. On 07/14/17 he was attempting to obtain plane tickets form an airline. On 07/15/17 he was yelling about his showers and on 07/16/17 he was observed in another residents room going through their belongings. The physician notes dated 07/10/17 noted he had demonstrated erratic impulsive behaviors at other facilities and while at this facility he was found to be quite delusional. He was noted by the physician to have behaviors that were keeping his roommate (Resident #4) awake at night. During an interview with Resident #1 on 08/01/17 at 9:19 AM, Resident #1 stated that Resident #4 was his previous roommate and they were good	F 514	room change 7/26/17. Social services coordinator also failed to document incident resulting in room change as intervention for resident #1 & #4. Staff Development coordinator began in-servicing 8/2/17 to all licensed nursing staff to ensure compliance with policy and expectations related to documentation and accuracy of medical records are met. Individual education was provided to social worker as it relates to documentation of residents behaviors and social wellbeing 8/1/17. Resident #1 MDS was reviewed and updated. Behavior care plan established. Nursing designee updated notes in chart to reflect verbal altercation 8/3/17. Social worker updated notes in chart to reflect verbal altercation and reason for room change 8/1/17. Resident #1 & #4 were immediately separated, assessed, and the room of resident #1 was changed on 7/26/17. All residents have the potential to be affected. A review of incidents from the last 30 days regarding resident to resident altercations will be completed to ensure nursing documentation is present. Incident reports and 24 hour shift to shift reports will be reviewed to ensure nursing documentation is present as indicated. Social Services coordinator will audit all active charts to ensure social services note include proper documentation related to behaviors and social well-being. Social services coordinator will also audit room changes for the last 30 days, and from this date forward to ensure social services	

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F 514	Continued From page 2 friends for a while until a few days ago. He stated that they "got into a knock down drag out" incident when Resident #4 became very loud. Resident #1 described a dual of both of them turning their televisions up louder and louder to drown the other's television noise out. Resident #1 stated Resident #4 started it but Nurse Aide (NA) #1 blamed Resident #1. Resident #1 stated he was offered a different room and moved within an hour or two. Review of the medical record nursing notes revealed no documentation of any resident to resident altercation or room change in Resident #1's medical record. Interview with the Social Worker on 08/01/17 at 1:36 PM revealed she came in one morning and learned that during the 3rd shift, Resident #1 and Resident #4 got into a confrontation and staff had separated them. She stated both residents gave different accounts of the incident and she proceeded to move Resident #1 to a different room. She stated she could not recall the date but referred to a room change form dated 07/26/17. She stated she did not write a note and expected the nurses to write the note of the incident. A phone interview was conducted with NA #1 on 08/01/17 at 2:48 PM. NA #1 stated she came in early one day on third shift, date unknown. She stated that Residents #1 and #4 were hollering at each other and Resident #1 threatened to kill Resident #4. She removed Resident #1, kept them separated and reported the incident to one of the nurses but she was unsure of which nurse. NA #1 stated Resident #1 was moved to a new room that day.	F 514	note includes documentation related to room change. DON/ADON & SDC began immediate in-servicing on 8/2/2017 and educations were completed on 8/4/2017 for licensed nursing staff related to the procedure and expectation regarding behavior management, documentation, and follow-up are met. 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 medical record to ensure compliance. DON/Designee will audit of incident reports and 24hour shift to shift report to ensure nursing documentation represents accuracy of medical record. Results of the audit will be taken to QAPI meeting to evaluate compliance. DON/designee will complete audit of incident reports and 24 hour shift to shift reports 5x a week x 4 weeks, weeks, weekly x 4 weeks then monthly x 3. Results of these audits will be taken to the QAPI Committee meeting monthly x 3 months, then quarterly until resolved. The DON/ADON is responsible for overall compliance.	

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An attempt to reach Nurse #1 by phone, who was scheduled as working the 3rd shift of 07/25/17-7/26/17 (11 PM - 7 AM), was unsuccessful.

Interview with the Assistant Director of Nursing on 08/01/17 at 3:48 PM revealed she could not find nursing notes about the incident. She stated she came in and learned about the altercation and heard Resident #1 had made a comment about strangling or choking Resident #4. A room change occurred that day. She stated she expected both the social worker and the nurse to make notes about the incident and that the nurse should have started a behavior monitoring sheet for 72 hours.

The Director of Nursing (DON) was interviewed on 08/01/17 at 3:55 PM. The DON stated she expected the nurse to document in the medical record when an altercation occurred as she would any change in behaviors.

The Administrator stated during interview on 08/01/17 at 4:40 PM that the medical record and incident report should have been completed about the incident leading up to the room change.

2. Resident #4 was admitted tot he facility on 07/05/17 with diagnoses including mood disorder.

His admission Minimum Data Set dated 07/17/17 noted he was cognitively intact. had behaviors of rejecting care and was totally dependent on staff for most activities of daily living skills.

On 08/01/17 at 11:24 AM Resident #4 stated during interview that Resident #1 was his

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roommate until he threatened to strangle him in front of Nurse Aide (NA) #1. Resident #4 stated Resident #1 was awake all night, turned on the air conditioning, radio and television full blast. He banged around the room. Recently, Resident #4 stated he and Resident #1 got into a screaming match at 6:00 AM about the noise and after they argued, Resident #1 was moved to a different room.

Review of the medical record nursing notes revealed no documentation of any resident to resident confrontation in Resident #4's medical record.

Interview with the Social Worker on 08/01/17 at 1:36 PM revealed she came in one morning and learned that during the 3rd shift, Resident #1 and Resident #4 got into an altercation and staff had separated them. She stated both residents gave different accounts of the incident and she proceeded to move Resident #1 to a different room. She stated she could not recall the date but referred to a room change form dated 07/26/17. She stated she did not write a note and expected the nurses to write the note of the incident.

A phone interview was conducted with NA #1 on 08/01/17 at 2:48 PM. NA #1 stated she came in early one day on third shift, date unknown. She stated that Residents #1 and #4 were hollering at each other and Resident #1 threatened to kill Resident #4. She removed Resident #1, kept them separated and reported the incident to one of the nurses but she was unsure of which nurse. NA #1 stated Resident #1 was moved to a new room that day.

An attempt to reach Nurse #1 by phone, who was

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scheduled as working the 3rd shift of 07/25/17-7/26/17 (11 PM - 7 AM), was unsuccessful.

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