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 ______	10/26/2017

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 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to update the resident care card and follow the care plan interventions for fall precautions to place a fall mat for 1 of 3 sampled residents (Resident #19). Findings included: Resident #19 was admitted to the facility on 11/02/16 with the diagnoses of seizure disorder and traumatic brain accident. The most recent annual Minimum Data Set (MDS) dated 09/21/17 indicated Resident #19 had moderately impaired cognition and needed extensive assistance with transfers, walking in the room and the corridor. Resident #19 was independent with 1 person assistance for toileting and was continent of bladder and occasionally incontinent of bowel. The MDS also indicated balance during transitions and walking was unsteady and Resident #19 was only able to stabilize with assistance and had impairment on both side of the upper extremities. The revised care plan dated 10/11/17 included a focus on falls and described Resident #19 as	F 282	F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLANS 1. THE ALLEGATION IS THAT THE FACILITY FAILED TO UPDATE THE RESIDENT KARDEX FOR RESIDENT #19 AND TO FOLLOW THE CAREPLAN INTERVENTIONS FOR FALL PRECAUTIONS. STAFF DEVELOPMENT COORDINATOR BEGAN INSERVICING ON 10/26/2017 LICENSED NURSING STAFF TO ENSURE COMPLIANCE RELATED TO INTERVENTIONS THAT WERE APPLIED TO THE CARE PLAN WERE IMPLEMENTED AND UTILIZED. RESIDENT #19 KARDEX AND CARE PLAN WAS REVIEWED AND UPDATED. FALL INTERVENTIONS WERE REVIEWED FOR APPROPRIATENESS AND PLACEMENT. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL ACTIVE CARE PLANS AND KARDEXS' WERE REVIEWED AND UPDATED AS INDICATED.	11/21/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/17/2017

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 282	Continued From page 1 alert only to self with poor safety awareness with a history of falls and the diagnosis of seizure disorder. The approaches for nursing included the fall prevention program if applicable, maintain a clutter and hazard free environment, and place a fall mat. During an observation at 12:30 PM on 10/24/17, Resident #19 had no fall mat and a bedside commode was stored in the bathroom along with a geriatric chair leaving a small area to access the toilet. During an observation at 8:42 AM on 10/25/17, Resident #19 was resting on the bed, dressed and wearing white socks without gripping. The bedside commode was stored in the bathroom and there was no fall mat. During an observation at 1:08 PM on 10/26/17, Resident #19 was resting in the bed and there was no fall mat. During an interview at 3:11 PM on 10/26/17, the second shift Nurse Aide (NA) #1 revealed she was responsible for the care and providing assistance to the bathroom for Resident #19 and toileting was offered approximately every 2 hours. She also revealed Resident #19 would often go to the bathroom without calling or waiting for assistance from staff. NA #1 revealed if a fall mat was needed for the resident she would have to ask the nurse for that information. NA #1 also revealed the fall prevention program was in place for Resident #19 which meant he/she needed assistance with transfers, walking, and toileting. NA #1 revealed direct care staff used a care card system that explained and identified the care needs of Resident #19. NA #1 revealed the card read: assistance with transfers by 2 staff,	F 282	3. DON, ADON, AND SDC BEGAN IMMEDIATE INSERVICING ON 10/26/2017. EDUCATIONS WERE COMPLETED ON 11/07/2017 FOR LICENSED NURSING STAFF RELATED TO PROCEDURES AND EXPECTATAION REGARDING FALL PREVENTION, INTERVENTION, AND KARDEX REVIEW TO ENSURE DOCUMENTATION AND FOLLOW UP ARE MET. EACH LICENSED NURSING STAFF HIRED AFTER THIS DATE WILL BE PROVIDED WITH A SIGNED EDUCATION REGARDING POLICY AND EXPECTATION RELATED TO CLINICAL DOCUMENTATION TO REFLECT ACCURACY OF MEDICAL RECORD TO ENSURE COMPLIANCE IS MET. 4. DON/DESIGNEE WILL COMPLETE AUDIT OF INCIDENT REPORTS, CARE PLANS, AND KARDEXES 5 TIMES A WEEK FOR 4 WEEKS, WEEKLY X 4 WEEKS, THEN MONTHLY X 3. RESULTS OF THESE REVIEWS WILL BE TAKEN TO THE QAPI MEETING MONTHLY TO ENSURE ONGOING SUBSTANSTANTIAL COMPLAINCE.THE RESULTS OF COMPLIANCE WILL BE REVIEWD EVERY MONTH X 3 MONTHS, THEN QUARTERLY UNTIL RESOLVED.THE DON/ADON IS RESPONSIBLE FOR OVERALL COMPLIANCE.	

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F 282	Continued From page 2 assistance with continence, bedfast for mobility and activity, but it did not include the fall mat. During an interview at 3:25 PM on 10/26/17, the second shift Nurse #1 revealed she was responsible for the care of Resident #19 and that she would be informed of any falls and new fall preventions during the nurse report. The information would also be in the resident's care plan. She indicated she would check during her shift to ensure the fall precautions were in place. Nurse #1 confirmed the fall mat was not in place and that the care card used by the direct care staff should be updated to use a fall mat. During an interview at 3:39 PM on 10/26/17, the DON revealed the direct care staff used a care card system that identified resident care needs and was updated with fall preventions and included the equipment used such as fall mats. The DON also revealed it was the Unit Manager and the nurses' responsibility to update fall preventions on the care cards. The DON confirmed the expectation of the Unit Manager and the nurses' was to update the card system used by the direct care staff when an intervention was added to the care plan and for those interventions to match and be implemented.	F 282		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		11/21/17

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F 323	Continued From page 3 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to implement planned interventions to minimize accidents and the potential for falls for 1 of 3 residents reviewed for accidents (Resident #19). Findings included: Resident #19 was admitted to the facility on 11/02/16 with the diagnoses of seizure disorder and traumatic brain accident. The most recent annual Minimum Data Set (MDS) dated 09/21/17 indicated Resident #19 had moderately impaired cognition and needed extensive assistance with transfers, walking in the room and the corridor. Resident #19 was independent with 1 person assistance for toileting and was continent of bladder and occasionally incontinent of bowel.	F 323	F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVISES 1. THE ALLEGATION IS THAT THE FACILITY FAILED TO UPDATE THE RESIDENT KARDEX FOR RESIDENT #19 AND TO FOLLOW THE CAREPLAN INTERVENTIONS FOR FALL PRECAUTIONS. STAFF DEVELOPMENT COORDINATOR BEGAN INSERVICING ON 10/26/2017 LICENSED NURSING STAFF TO ENSURE COMPLIANCE RELATED TO INTERVENTIONS THAT WERE APPLIED TO THE CARE PLAN WERE IMPLEMENTED AND UTILIZED. RESIDENT #19 KARDEX AND CARE PLAN WAS REVIEWED AND UPDATED. FALL INTERVENTIONS WERE	

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F 323	Continued From page 4 The MDS also indicated balance during transitions and walking was unsteady and was only able to stabilize with assistance. Review of the revised care plan for Resident #19 dated 10/11/17 included a focus on falls and described Resident #19 as alert only to self with poor safety awareness and a history of falls with a diagnosis including seizure disorder and being a fall risk. The approach for nursing was to ensure gripper socks were in place as proper foot wear, maintain a clutter and hazard free environment, provide a bedside commode and encourage to use, and place a fall mat. Review of the incident reports revealed Resident #19 had fallen on 10/14/17 and received 2 skin tears on the arm. The fall occurred in the bathroom. During an observation at 12:30 PM on 10/24/17, Resident #19 had no fall mat and the bedside commode was being stored in the bathroom along with a geriatric chair leaving a small area to access the toilet. During an observation at 8:42 AM on 10/25/17, Resident #19 was resting on the bed, dressed and wearing white socks without gripping. The bedside commode was being stored in the bathroom and there was no fall mat. During an observation at 1:08 PM on 10/26/17, Resident #19 was resting in the bed wearing white socks without gripping and the bedside commode was stored in the bathroom and there was no fall mat. During an interview at 3:11 PM on 10/26/17, the	F 323	REVIEWED FOR APPROPRIATENESS AND PLACEMENT. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL ACTIVE CARE PLANS AND KARDEXS' WERE REVIEWED AND UPDATED AS INDICATED. 3. DON, ADON, AND SDC BEGAN IMMEDIATE INSERVICING ON 10/26/2017. EDUCATIONS WERE COMPLETED ON 11/07/2017 FOR LICENSED NURSING STAFF RELATED TO PROCEDURES AND EXPECTATAION REGARDING FALL PREVENTION, INTERVENTION, AND KARDEX REVIEW TO ENSURE DOCUMENTATION AND FOLLOW UP ARE MET. EACH LICENSED NURSING STAFF HIRED AFTER THIS DATE WILL BE PROVIDED WITH A SIGNED EDUCATION REGARDING POLICY AND EXPECTATION RELATED TO CLINICAL DOCUMENTATION TO REFLECT ACCURACY OF MEDICAL RECORD TO ENSURE COMPLIANCE IS MET. 4. DON/DESIGNEE WILL COMPLETE AUDIT OF INCIDENT REPORTS, CARE PLANS, AND KARDEXES 5 TIMES A WEEK FOR 4 WEEKS, WEEKLY X 4 WEEKS, THEN MONTHLY X 3. RESULTS OF THESE REVIEWS WILL BE TAKEN TO THE QAPI MEETING MONTHLY TO ENSURE ONGOING SUBSTANSTANTIAL COMPLAINCE.THE RESULTS OF COMPLIANCE WILL BE REVIEWD EVERY MONTH X 3	

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F 323	Continued From page 5 second shift Nurse Aide (NA) #1 revealed she was responsible for the care and providing assistance to the bathroom for Resident #19 and toileting was offered approximately every 2 hours. She also revealed Resident #19 would often go to the bathroom without calling or waiting for assistance from staff. NA #1 revealed if a fall mat was needed for the resident she would have to ask the nurse for that information. NA #1 also revealed the fall prevention program was in place for Resident #19 which meant he/she needed assistance with transfers, walking, and toileting. NA #1 revealed direct care staff used a care card system that explained and identified the care needs of Resident #19. NA #1 revealed the card read: assistance with transfers by 2 staff, assistance with continence, bedfast for mobility and activity, but it did not include the fall mat. During an interview at 3:25 PM on 10/26/17, the second shift Nurse #1 revealed she was responsible for the care of Resident #19 and that she would be informed of any falls and new fall preventions during the nurse report. The information would also be in the resident's care plan. She indicated she would check during her shift to ensure the fall precautions were in place. Nurse #1 confirmed the fall mat was not in place and that the care card used by the direct care staff should be updated to use a fall mat. During an interview at 3:39 PM on 10/26/17, the DON revealed the direct care staff used a care card system that identified resident care needs and was updated with fall preventions and included the equipment used such as fall mats. The DON also revealed it was the Unit Manager and the nurses' responsibility to update fall preventions on the care cards. The DON	F 323	MONTHS, THEN QUARTERLY UNTIL RESOLVED.THE DON/ADON IS RESPONSIBLE FOR OVERALL COMPLIANCE.	

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F 323	Continued From page 6 confirmed the expectation of the Unit Manager and the nurses' was to update the card system used by the direct care staff when an intervention was added to the care plan and for those interventions to match and be implemented.	F 323		