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 02/05/2025

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/02/25 through 02/05/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 37X011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/02/25 through 02/05/25. Event ID# 37X011. The following intakes were investigated: NC00218862, NC00218994, NC00219625, NC00220462, and NC00221584. 10 of the 10 complaint allegations did not result in deficiency.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication.	F 636		3/5/25

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

Electronically Signed | 02/21/2025

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F 636	Continued From page 1 (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)	F 636		

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F 636	Continued From page 2 (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the Care Area Assessment (CAA) comprehensively to address the underlying causes and contributing factors of the triggered areas for 2 of 5 sampled residents reviewed for unnecessary medications (Residents #10 and Resident #11). The findings included: a. Resident #10 was admitted to the facility on 09/02/23 with diagnoses including non-Alzheimer's dementia, anxiety disorder, and osteoarthritis. A review of Section V (CAA Summary) of the significant change in status MDS assessment dated 08/14/24 revealed 10 care areas were triggered for Resident #10. The MDS Coordinator did not provide any information in the analysis of findings for 9 of the 10 triggered areas to describe the nature of Resident 10's problems, possible causes, contributing factors, risk factors related to the care area, and reasons to proceed with care planning for the following triggered care areas: 1. Delirium 2. Cognitive loss/dementia 3. Visual functions 4. Communication 5. Urinary incontinence and indwelling catheter 6. Behavioral symptoms 7. Falls 8. Pressure ulcer/injury 9. Psychotropic drug usage	F 636	On 2/4/25, during the facilities annual state survey it was determined that the facility failed to complete the Care Area Assessment (CAA) to address the underlying causes and contributing factors of the triggered areas for 2 of 5 sampled residents reviewed for unnecessary medications. -The facility Licensed Nursing Home Administrator is ultimately responsible to ensure that the plan of correction is implemented and followed. All residents have the potential to be impacted by this deficient practice. -A Care plan/Minimum Data Set (MDS) resident record review was completed for resident #10 and resident #11 by the Minimum Data Set (MDS) consultant and the Minimum Data Set (MDS) coordinator. It was determined that both residents have an accurate Minimum Data Set (MDS) Assessment and have comprehensive careplans that reflect the care that is being provided. Care plan progress notes were documented in the medical record to address the underlying causes and contributing factors for the triggered care areas by the MDSC on 2/20/2025. A Care Area Assessment (CAA) will be completed as appropriate with their next scheduled assessment or significant change as appropriate and as outlined in the Resident Assessment Instrument (RAI) manual.	

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F 636	Continued From page 3 b. Resident #11 was admitted to the facility on 03/01/23 with diagnoses including diabetes mellitus, non-Alzheimer's dementia, anxiety disorder, and depression. A review of Section V (CAA Summary) of the annual MDS assessment date 08/23/24 revealed 8 care areas were triggered for Resident #11. The facility did not provide any information in analysis of findings for all 8 triggered areas to describe the nature of Resident 11's problems, possible causes, contributing factors, risk factors related to the care area, and reasons to proceed with care planning for the following triggered care areas: 1. Cognitive loss/dementia 2. Activities of daily living functional/rehabilitation potential 3. Urinary incontinence and indwelling catheter 4. Mood stated 5. Falls 6. Nutritional status 7. Pressure ulcer/injury 8. Psychotropic drug use During an interview conducted on 02/04/25 at 9:55 AM, the MDS Coordinator confirmed 9 of the 10 triggered care areas for Resident #10's MDS dated 08/14/24 and all 8 triggered care areas for Resident #11's MDS dated 08/23/24 were submitted without providing pertinent information in the analysis of findings in Section V. She explained she started working as the MDS Coordinator last November and both MDS assessments were submitted by the former MDS Coordinator. She did not know how both incidents occurred and acknowledged that it was an error to submit an annual or significant change in	F 636	On 2/14/25, the Minimum Data Set (MDS) Nurse Consultant conducted a 100% audit of all residents most recent comprehensive Minimum Data Set (MDS) to ensure that all residents with a comprehensive Minimum Data Set (MDS) assessment had the Care Area Assessment (CAA) completed to include addressing the underlying causes and contributing factors of the triggered areas. For any resident identified during the audit without a Care Area Assessment (CAA) completed as appropriate per the assessment, the Minimum Data Set (MDS) Nurse and/or Minimum Data Set (MDS) Consultant completed progress notes in the medical record to address the underlying causes and contributing factors of the triggered areas. This audit was completed by 2/20/25. On 2/18/25, the Minimum Data Set (MDS) Consultant conducted 100% education for the Dietary Manager, Assistant Director of Nursing, the Activities Director, the Social Worker and the Minimum Data Set (MDS) coordinator on how to complete a Care Area Assessment (CAA) as outlined the Resident Assessment Instrument (RAI) manual. Any newly hired MDS, Assistant Director of Nursing, Dietary Manager, Activity Director, Social Worker, or Assistant Director of Nursing to include agency staff will complete education during orientation. Beginning 2/24/25, Registered Nurse (RN) Assistant Director of Nursing will	

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F 636	Continued From page 4 status MDS without completing analysis of findings for all the triggered areas comprehensively. On 02/04/25 at 11:25 AM an interview was conducted with the Director of Nursing. She stated all the CAAs must be individualized and completed comprehensively. It was her expectation for the MDS Coordinators to complete the analysis of findings for all the triggered areas in Section V comprehensively before submission. An interview was conducted with the Administrator on 02/04/25 at 2:54 PM. She expected the MDS Coordinator to follow MDS guidelines to ensure all the CAAs included at least the nature of problems, causative factors, and reasons to proceed to care plan before submission.	F 636	audit the completed Care Area Assessments (CAAs) for new admissions, significant change, and annual assessments weekly for 4 weeks to ensure they are completed appropriately as outlined in the Resident Assessment Instrument (RAI) manual. Any concerns will be discussed with the Minimum Data Set (MDS) consultant, and the Licensed Nursing Home Administrator and corrections will be made as necessary. The Director of Nursing or Assistant Director of Nursing will present the findings of these audits monthly for 2 months to the Quality Assurance Performance Improvement committee for review and a decision will be made if the audits continue. Date of compliance will be: 3/5/25	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and	F 644		3/5/25

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F 644	Continued From page 5 all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) application was completed for a resident who had a new psychiatric diagnosis for 1 of 1 resident (Resident #10) reviewed for PASRR. The findings included: Resident #10 was admitted to the facility 9/2/23 with diagnoses that included polyosteoarthritis, and generalized anxiety disorder. Resident #10's care plan initiated on 4/8/24 indicated Resident #10 had actual acute confusional state characterized by behaviors, altered thought process, delusions and hallucinations related to legal blindness and hearing deficit. A review of Resident #10's medical record indicated hallucinations was added to her diagnoses list effective 8/1/24. There was no information in Resident #10's medical record regarding the PASRR number or if a new application for PASRR was completed by facility staff after Resident #10 was diagnosed with hallucinations. The most recent quarterly Minimum Data Set assessment dated 11/26/24 indicated Resident #10 did not have hallucinations.	F 644	1. On 2/3/25 during the annual facility survey, resident #10 did not have a level II pre-admission screening and resident review (PASARR) application or level II pre-admission screening and resident review (PASARR) on file. -The facility Licensed Nursing Home Administrator is responsible for ensuring that this plan of correction is implemented and followed. All residents have the potential to be affected by this deficient practice. -On 2/14/2025, a level II pre-admission screening and resident review (PASARR) application was completed and submitted by the facility social worker and the business office manager for resident #10. 2. On 2/14/25, the Nurse Consultant and the Business Office Manager began conducting a 100% audit of all residents to ensure any resident who is eligible to be screened for a level II pre-admission screening and resident review (PASARR) was submitted. Any resident who required a new submission or revision of their pre-admission screening and resident review (PASARR) was completed and submitted. The audit was completed on 2/21/25.	

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F 644	Continued From page 6 An interview with the Social Worker (SW) on 2/3/25 at 3:07 PM revealed he had worked at the facility since the end of November 2024, but he did not have anything to do with PASRR. The SW stated that the Business Office Manager was responsible for PASRR, but he was able to look up Resident #10's PASRR information during the interview. The SW shared that Resident #10 currently had a PASRR Level I. An interview with the Business Office Manager on 2/3/25 at 3:11 PM revealed she was responsible for obtaining the PASRR information prior to residents being admitted to the facility, but she was not sure who would have submitted a new PASRR application for residents who had new mental health diagnoses. The Business Office Manager stated that the previous Social Worker used to be responsible for PASRR, but after she left employment the Business Office Manager had taken over obtaining the PASRR information for the new admissions. During a follow-up interview with the Business Office Manager on 2/5/25 at 8:33 AM, she retrieved Resident #10's PASRR information which revealed that the last time a request for evaluation was submitted was on 8/29/23 wherein Resident #10 was given a PASRR Level I. The Business Office Manager stated that the previous Social Worker was responsible for submitting a new PASRR application whenever there were new mental health diagnoses, but she did not know who was supposed to do it now. An interview with the Administrator on 2/5/25 at 8:38 AM revealed the Admissions Director and the Business Office Manager shared responsibility in obtaining PASRR information for	F 644	3. 2/19/25, A Licensed Nursing Home Administrator provided education to the facility Licensed Nursing Home Administrator, Director of Social Services, Director of Admissions, and Business Officer Manager on the requirements of Level I and Level II pre-admission screening and resident review (PASARRs) as outlined in the State Operations Manual. After 2/19/25, any newly hired facility Licensed Nursing Home Administrator, Directors of Admission, Social Worker, or Business Officer Managers to include agency will complete in-service education during orientation. 4. Beginning 02/24/2025, the Director of Social Work and the Director of Admissions will audit 4 residents records per week to include any new admissions or residents with a change of condition weekly for 4 weeks to determine if the resident□s pre-admission screening and resident review (PASARR) is up to date. Any concerns will be corrected immediately. -The Admissions Director will screen all new admissions on the day of admission to ensure a Level II pre-admission screening and resident review (PASARR) screening application has been completed and submitted if appropriate as outlined in the State Operations Manual. The Licensed Nursing Home Administrator will present the findings of these audits monthly for 2 months to the Quality Assurance Performance	

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F 644	Continued From page 7 new residents. The Administrator stated that they talked about any new mental health diagnoses in the morning meetings, and the Social Worker would be responsible for submitting a new PASRR application, but he had not been trained yet. She further stated that the current Social Worker was getting ready to be trained on the PASRR process. The Administrator shared that the previous Social Worker used to deal with PASRR, but they did have a vacancy at some point, which could have contributed to the PASRR applications not being done.	F 644	Improvement committee for review and a decision will be made if the audits will continue. 5. Date of compliance: 3/5/25	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to post cautionary and safety signage outside a resident's room that indicated the use of oxygen for 1 of 1 resident reviewed for respiratory care (Resident #239). The findings included: Resident #239 was admitted to the facility on 01/16/25 with diagnoses that included acute respiratory failure with hypoxia (a condition in which there is an inadequate supply of oxygen to	F 695	1. During the recent annual recertification survey, the facility failed to post cautionary and safety signage outside a resident's room that indicated the use of oxygen for 1 of 1 residents reviewed for respiratory care (Resident #239). -The facility Licensed Nursing Home Administrator ultimately has the responsibility to ensure that the plan of correction is implemented and followed. All residents who are receiving Oxygen	3/5/25

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F 695	Continued From page 8 the body's tissues). A review of Resident #239's physician orders revealed an order dated 01/17/25 for oxygen to be administered continuously via nasal cannula at 2 liters per minute, may titrate to keep oxygen (O2) saturation greater than 90%. A review of the Admission Minimum Data Set (MDS) dated 01/22/25 indicated Resident #239 was cognitively intact and coded for oxygen use. An observation on 02/02/25 at 11:54 AM revealed Resident #239 sitting in his wheelchair by his bed with oxygen being administered by an oxygen concentrator. He was holding the nasal cannula in his left hand and indicated he had just removed the nasal cannula to go to the bathroom. There was no signage posted outside Resident #239's room indicating supplemental oxygen was in use. An observation of Resident #239 on 02/03/25 at 8:13 AM revealed he was sitting in his wheelchair by his bed with oxygen being administered via nasal cannula by an oxygen concentrator. There was no cautionary or safety signage posted outside his room indicating supplemental oxygen was in use. An interview conducted on 02/04/25 9:46 AM with Nurse #1 revealed when there was a new resident with orders for oxygen, the nurse who completed the admission would place oxygen in use signage on the resident's door. She indicated any staff member who was aware of oxygen being in use could put up a sign. She was not aware Resident #239 did not have oxygen signage posted.	F 695	therapy have the potential to be affected by this deficient practice. -On 2/4/25, the Unit Manager placed safety signage to indicate Oxygen in use/No Smoking on Resident #239□s door. 2. On 2/4/25, the Assistant Director of Nursing and the Unit Manager conducted a 100% audit of all residents who have an order for oxygen to ensure the appropriate signage for safety to indicate Oxygen in use/No Smoking was on these resident doors as appropriate. 3. On 2/4/25, the Staff Development Coordinator (SDC) conducted an in-service with all licensed nurses to include agency nurses to ensure that any resident with an order for oxygen would have signage placed on the door for safety to indicate Oxygen in use/No Smoking. Any newly hired licensed nurses or agency nurses will receive education during orientation. All education will be completed by 2/21/25. Any nurse to include agency staff who have not completed the education by 2/21/25 must complete prior to their next scheduled shift. 4. Beginning 2/24/25, the Assistant Director of Nursing and the Unit Manager will audit 4 residents per week for 4 weeks to ensure safety signage to indicate Oxygen in Use/No Smoking is placed on the door of residents□ room who have an order for oxygen. Any concerns will be	

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F 695	Continued From page 9 On 02/04/25 at 9:52 AM an interview was held with the Director of Nursing (DON). She indicated the nurse who admitted a new resident was responsible for placing the oxygen in use signage on the resident's door. The DON continued to voice the oxygen in use signage should have been placed on Resident #239's door and was not certain why the signage was not in place. An interview with the Administrator on 02/05/25 at 9:43 AM revealed nurses should validate physician orders related to oxygen and place oxygen signage on the resident's door.	F 695	corrected immediately. The Director of Nursing or Assistant Director of Nursing will present the findings of these audits monthly for 2 months to the Quality Assurance Performance Improvement committee for review and a decision will be made if the audits will continue. 5. Date of compliance: 3/5/25	
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 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	F 761		3/5/25

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F 761	Continued From page 10 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, staff interviews and record review, the facility failed to remove expired medication in accordance with manufacturer's expiration date and failed to date a time sensitive eye drops after it was opened and stored at room temperature for 1 or 2 medications carts observed during medication storage checks (Medication Cart #1). The findings included: Review of the manufacturer's package insert for Latanoprost eye drops revealed an unopened bottle should be stored under refrigeration between 36° to 46° Fahrenheit (F) and protected from light. Once opened, Latanoprost may be stored at room temperature up to 77° F for up to six weeks. An observation was conducted on 02/03/25 at 3:49 PM for Medication Cart #1 in the presence of Nurse #2. The observation revealed the following: - One opened bottle of Latanoprost 0.005% eye drop (medication used to treat glaucoma) for Resident #14 was stored at room temperature without an opening date and ready to be used. A sticker for the nurse to record the opening date remained blank. - One opened bottle of docusate sodium liquid (Medication used to prevent and treat occasional constipation) with concentration of 50 milligrams	F 761	1. On 2/3/25, during the facilities annual recertification survey the facility failed to date a time sensitive eye drop (Latanoprost) after it was opened and stored at room temperature for 1 of 2 medications carts observed during medication storage checks (Medication Cart #1). -The facility Licensed Nursing Home Administrator ultimately has the responsibility to ensure that the plan of correction is implemented and followed. All residents have the potential to be affected by this deficient practice. -On 2/3/25, the Unit Manager and Nurse #2 sent the unlabeled/undated eye drop back to the pharmacy and placed a new bottle of Latanoprost eye drops on the medication cart with an open date and expiration date appropriately written in. The new bottle of eye drops was provided at no charge to the resident. 2. On 2/4/25, the Unit Manager and the Assistant Director of Nursing completed a 100% audit of both medication carts in-house to ensure there were no other opened medications requiring a date after opening or expired medications on the medication carts. Any areas of concern were addressed immediately during the	

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	345396	A. BUILDING _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 11 (mg) per 5 milliliters (ml) expired on 01/31/25 with 15 ounces remaining in the bottle and ready to be used. Review of physician's orders revealed Resident #14 had an active order to receive one drop of Latanoprost solution in both eyes once daily in the evening started 04/18/24. The medication administration records indicated Resident #14 had received Latanoprost eye drops as ordered since its initiation on 04/18/24. During an interview conducted on 02/03/25 at 3:53 PM, Nurse #2 stated the medication carts were checked thoroughly by the third shift nurse on each Sunday to ensure proper storage condition and discard expired medications. Nurse #2 stated they had been instructed to check the medication for expiration each time before administration. She did not know why the eye drops and the stool softener laxative was not identified by the nurse who checked the medication cart last Sunday. She acknowledged that the eye drops needed to be dated after the bottle had been opened and stored in the room temperature, and the expired docusate solution needed to be discarded. An interview was conducted with the Director of Nursing (DON) on 02/04/25 at 10:17 AM. She stated it was her expectation for all the nurses to date latanoprost eye drops once a new bottle was opened, and keep the facility free of expired medication all the time. During an interview conducted with the Administrator on 02/04/25 at 2:54 PM, she expected nursing staff to check the expiration	F 761	audit. 3. Beginning 2/07/25 and 2/13/2025, the Staff Development Coordinator provided education to 100% of all nurses and medication aides to include agency nurses with a focus on the requirements for the labeling, storage, return, disposable of medications, and the dating of opened medications as outlined in the facility policy and procedures. All in-service education will be completed by 2/21/25. Any licensed nurses or medication aides to include agency nurses who have not completed the education by 2/21/25 will be in serviced prior to their next scheduled shift.¿¿Any newly hired licensed nurses or medications aides to include agency nurses will receive in-service education during orientation. 4. Beginning 2/24/25, the Assistant Director of Nursing or the Unit Manager will audit both medication carts 2 times weekly for 4 weeks to ensure that all medications are dated as appropriate per the facility policy and procedure and there are no expired medications on the cart. Any concerns will be reported to the Assistant Director of Nursing or the Director of Nursing and addressed immediately. The Director of Nursing or Assistant Director of Nursing will present the findings of these audits monthly for 2 months to the Quality Assurance Performance Improvement committee for	

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F 761	Continued From page 12 date of medication routinely and date latanoprost once it was opened. It was her expectation for all the nurses to follow the manufacturer's guidelines to ensure the facility was free of expired medications.	F 761	review and a decision will be made if the audits continue. 5.Date of compliance: 3/5/25	