PRINTED: 01/06/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245205	B. WING			С
		345305	B. WING _			12/05/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
SMOKY R	DGE HEALTH & REHAB	ILITATION		310 PENSACOLA ROAD		
		-		BURNSVILLE, NC 28714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)	
E 000	Initial Comments		EC	000		
F 000		3.73 Emergency ID #TBOU11.	FC	000		
F 584	survey was conducted total of 6 allegations was substantiated. Ev	complaint investigation d 12/02/19 to 12/05 19. A were investigated and one vent ID #TBOU11. ble/Homelike Environment	F 5	.84		1/2/20
SS=E			FS	104		1/2/20
	§483.10(i) Safe Envir The resident has a rig comfortable and hom but not limited to rece supports for daily living	iht to a safe, clean, elike environment, including iving treatment and				
	homelike environmen use his or her person possible. (i) This includes ensureceive care and serve physical layout of the independence and do (ii) The facility shall exthe protection of the ror theft.	clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can rices safely and that the facility maximizes resident rices not pose a safety risk. Exercise reasonable care for resident's property from loss				
	- ''''	eeping and maintenance maintain a sanitary, orderly, ior;				
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>	TITLE		(X6) DATE

Electronically Signed 12/24/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345305	B. WING			12/	05/2019
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	03/2019
				;	310 PENSACOLA ROAD		
SMOKY R	IDGE HEALTH & REHAB	BILITATION		ı	BURNSVILLE, NC 28714		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 584	Continued From page	e 1	F	584			
		ed and bath linens that are	' '	00-			
	in good condition;	ed and batti linens that are					
	§483.10(i)(4) Private	closet space in each					
		ecified in §483.90 (e)(2)(iv);					
	§483.10(i)(5) Adequal levels in all areas;	ite and comfortable lighting					
	levels. Facilities initia	table and safe temperature lly certified after October 1, a temperature range of 71 to					
	sound levels.	maintenance of comfortable					
	_	ns and interviews the facility			(1)The facility failed to maintain clean		
		an privacy curtains for 1 of			privacy curtain for 1 of 12 resident roor	ns	
		300 hall (room 313), failed			on 300 (room 313), failed to properly		
	to properly label and				label and store personal care equipment		
		athrooms (bathroom in room in a clean and sanitary			in 1 of 9 bathrooms (bathroom 402), fait to maintain a clean and sanitary geriatr		
	, ,	f 1 geriatric chair, failed to			chair for 1 of 1 geriatric chair, failed to		
		r in 1 resident room and			maintain a clean floor in 1 resident roor	n	
	bathroom (room 314)	, failed to maintain clean			and bathroom (room 314), failed to		
	_	nd baseboards for 2 of 4			maintain clean and sanitary floor in		
		alls), failed to maintain clean			baseboards for 2 of 4 halls (300 and 40		
		ills (300 and 400 hall), and			halls), failed to maintain clean walls on		
	hall) for 1 of 4 halls.	an and sanitary doors (300			out of 4 halls (300 and 400 hall), failed maintain clean and sanitary doors (300		
	Findings included:				hall) for 1 of 4 halls. Staff Developmer coordinator began in-servicing 12/5/19 all staff to ensure compliance with police	to	
	A. An observation of	room 313 on 12/02/19 at			and expectations related to proper	-	
		th privacy curtains had			housekeeping were met; related to		
	brown stains on them	1.			interventions applied to provide a safe, clean, comfortable, homelike		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		ATE SURVEY OMPLETED
							С
		345305	B. WING _				12/05/2019
NAME OF P	ROVIDER OR SUPPLIER	t e		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CMOKA B	IDCE HEALTH & DE	HARMITATION		31	10 PENSACOLA ROAD		
SWICKTR	IDGE HEALTH & RE	HABILITATION		В	URNSVILLE, NC 28714		
(X4) ID	SUMMAR	RY STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ı	(X5)
PREFIX TAG	,	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
F 584	Continued From p	page 2	F 5	584			
	An observation of	f room 313 on 12/03/19 at 3:30			environment. Room 313 privacy curta	ain	
	PM revealed both	n privacy curtains had brown			was replaced immediately. All other		
	stains on them.				rooms were checked to identify if any		
					other privacy curtained needed to be		
	An observation of	f room 313 on 12/04/19 at 8:54			replaced and replaced as needed. The		
	AM revealed both	n privacy curtains had brown			toothbrush, personal items, and bed p		
	stains on them.				in bathroom of 402 where disposed of	f	
					immediately and items replaced with		
		f room 313 on 12/05/19 at 8:28			resident specific labels in individual		
		n privacy curtains had brown			receptacles. The geriatric chair was d	•	
	stains on them.				cleaned 12/5/19 per the cleaning sche	edule	
			completed by 11-7 staff. The floor in				
		the Director of Nursing (DON)			resident room 314 was cleaned		
		15 AM revealed the privacy e clean and free of stains. She			immediately. Residents in A and B be- were temporarily relocated and the flo		
		see a visibly soiled privacy			stripped and waxed 12/5/19.	iOi	
		ld report it to housekeeping so			Housekeeping staff were immediately		
	they can replace	· · · · · · · · · · · · · · · · · · ·			assigned 12/5/19 to cleanse baseboa		
	andy carriopiace				walls and doorways initially to 300 and		
	B. An observatio	n of the shared bathroom of			400 hall, and then through the facility		
	room 402 on 12/0	02/19 at 11:59 AM revealed 2			ensure compliance.		
	unlabeled bed pa	ins were stored in the same bag			•		
	hanging from the	handrail and 2 unlabeled			(2)All residents have the potential to b	е	
	toothbrushes and	l an unlabeled hairbrush were			affected. Facility rounds have been		
	stored in a clear of	container on the sink.			assigned to all administrative staff.		
					Housekeeping rounds and deep clear	nsing	
		f the shared bathroom of room			schedule reviewed and revised as		
		at 3:16 PM revealed 2 unlabeled			indicated. Administrator/DON and		
		ored in the same bag hanging			Housekeeping Supervisor will audit al	I	
		and 2 unlabeled toothbrushes			room rounds and deep cleaning		
		hairbrush were stored in a clear			schedules to ensure compliance		
	container on the	SINK.			established. Administrator/DON or		
	An chaamietiese et	f the chared bethreem of			designee will round daily		
		f the shared bathroom of room at 8:50 AM revealed 2 unlabeled			(3)DON/ADON & SDC bogon immodia	ate	
		ored in the same bag hanging			(3)DON/ADON & SDC began immedia in-servicing on 12/5/19/ and education		
		and 2 unlabeled toothbrushes			were completed on 12/18/19 for all sta		
		hairbrush were stored in a clear			related to the procedure and expectat		
	container on the				to maintain safe, clean, comfortable	1011	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		re survey MPLETED
		345305	B. WING _			1	C 2/05/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		2/00/2010
				3.	10 PENSACOLA ROAD		
SMOKY R	IDGE HEALTH & REHA	BILITATION		В	BURNSVILLE, NC 28714		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 584	Continued From pag	e 3	F t	584			
					homelike environment are met. Deep		
		shared bathroom of room			cleaning schedule will include 10-15		
		:29 AM revealed 2 unlabeled			rooms weekly and be ongoing thereaft		
	•	l in the same bag hanging			Stripping and waxing of the facility floo		
		2 unlabeled toothbrushes			schedule will include1 room weekly un	til	
		rbrush were stored in a clear			all rooms are completed. Rooms in		
	container on the sink				greatest need will be determined by ro	om	
	An intonious with the	DON on 12/05/19 at 9:17			rounds. 300 hall and 400 hall to be stripped and waxed by January 2nd, 2	010	
		hbrushes and hair brush			with replacement of baseboards at time		
		d the bedpans should have			stripping hallways. Each other hall in	C OI	
		gged separately. She stated			facility will be stripped and waxed with		
		iced the unlabeled items and			baseboards replaced as needed.		
	the bed pans bagged	I together when room rounds			Administrator/DON and Housekeeping		
	were done daily.				Supervisor/designee will complete aud	lit of	
					room rounds and deep cleaning report		
		f Resident #78's geriatric			5x a week x 4 weeks, weekly x 4 week	S	
		2:59 PM revealed dried food			then monthly x 3. Each housekeeping		
	on the right arm rest	and right side of the chair.			staff member hired after this date will be provided with a signed education	e	
		sident #78's geriatric chair			regarding policy and expectation relate		
		PM revealed dried food on			to facility cleaning and follow through to		
	the right arm rest and	d right side of the chair.			reflect safe, clean, comfortable, homel	ike	
	A L	-:			environment to ensure compliance.		
		esident #78's geriatric chair			(4)) I a va alca anima (da ainma a vvilla annula	4-	
		AM revealed dried food on dright side of the chair.			(4)Housekeeping/designee will comple audit of facility room rounds and deep	eie	
	the fight and rest and	a fight side of the chair.			cleaning schedules for potential		
	An observation of Re	esident #78's geriatric chair			interventions and documentation that r	mav	
		AM revealed dried food on			be required. Results of these reviews v		
		d right side of the chair.			be taken to the QAPI Committee meet		
	3				monthly to ensure ongoing substantial	J	
	An interview with the	DON on 12/05/19 at 9:20			compliance. The results of compliance	will	
	AM revealed geriatric	c chairs should be clean and			be reviewed every month x 3 months a		
		he stated third shift cleaned			the monthly QAPI meeting, then quarte		
	_	nd Resident #78's geriatric			at QAPI meeting to maintain compliand		
	chair was last cleane	d 11/28/19.			The Administrator (LNHA) is responsib	le	
					for overall compliance. The		
	D. An observation of	f room 314 on 12/03/19 at			DON/designee will present results of		

Facility ID: 923575

		COMI	DATE SURVEY COMPLETED C				
		345305	B. WING _			1	C / 05/2019
	ROVIDER OR SUPPLIER	BILITATION		310	REET ADDRESS, CITY, STATE, ZIP CODE D PENSACOLA ROAD JRNSVILLE, NC 28714	<u>, 12</u>	700/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 584 Continued From			F 5	584			
	3:22 PM revealed the floor of the room and bathroom was sticky. audits to the QAPI committee. (5) The facility will be in compliance as or 01/02/2020.		s of				
	AM revealed dried sl	om 314 on 12/04/19 at 8:55 hoe prints on the floor of the f the shared bathroom of 314			01/02/2020.		
	AM revealed the floor were sticky. An interview with the on 12/05/19 at 9:05 a swept and mopped of Supervisor stated the facility last month an using bleach to clear the bleach had taker 314 and made the flousekeeping Super cleaned every 2 weeken 12/03/19. He state	om 314 on 12/05/19 at 8:23 or of the room and bathroom Housekeeping Supervisor AM revealed rooms were daily. The Housekeeping ere was a stomach bug in the d housekeeping staff were n. He stated it was possible in the wax off the floor in room for sticky. The rvisor stated rooms get deep eks and he cleaned room 314 ted he had planned on the facility but had not gotten					
	9:11 AM revealed state baseboards on both of the hall and conting An observation of the wall at the same date marks from the beging continuing to the end the hall. An observation hall at the same material on both door floor on 300 hall at the revealed dirt and determined the same material or so the hall at the hall at the same material or so the hall at the same material or so the hall at the same material or so the hall at the same date.	f the 300 hall on 12/04/19 at ains and debris on the sides of the hall from the top nuing to the end of the hall. The lower part of the 300 hall and the and time revealed scuff and the hall on both side of tion of the double doors on date and time revealed dried was. An observation of the ne same date and time or is where the floor meets the e entire length of 300 hall.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		OATE SURVEY OMPLETED
		345305	B. WING _			C 12/05/2019
	ROVIDER OR SUPPLIER	BILITATION		STREET ADDRESS, CITY, STATE, 310 PENSACOLA ROAD BURNSVILLE, NC 28714	, ZIP CODE	12/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 584	Continued From pa	ge 5	F 5	584		
	12/05/19 at 8:25 AM on the baseboards of the top of the hall are hall. An observation hall wall revealed so of the 300 hall and of hall on both side of on 300 hall had drie observation of the fl and debris where the along the entire length of the fl and debris where the halong the entire length of the hall on the hall planned on so but they need the had planned on so but he had not gotte housekeeping Supursually stripped and close to Christmas. The Administrator alto had not gotten to it is out a color. An interview with the 9:22 AM revealed so Housekeeping Superwalls on 300 and 40 picked out a color you housekeeping staff waxing and stripping in the process of try 400 hall into a mem focused on getting the stripping to the process of try 400 hall into a mem focused on getting the process of try 400 hall into a mem focused on getting the process of try 400 hall into a get	e Housekeeping Supervisor AM revealed there was no or the baseboards or double led to be cleaned. He stated stripping and waxing the floors en around to it. The ervisor stated the floors are I wax the floor once a year He stated he had talked with rout painting the walls but he yet and they had not picked e Administrator on 12/05/19 at the had talked with the ervisor about painting the on halls but they had not				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345305	B. WING _			C 12/05/2019	
	ROVIDER OR SUPPLIER	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 310 PENSACOLA ROAD BURNSVILLE, NC 28714	 	12/03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 584	on both sides of the and continuing to the	and debris on the baseboards hall from the top of the hall	F 5	584			
	and debris where the along the entire leng observation of the lo	e floor meets the baseboards					
	AM revealed stains a on both sides of the and continuing to the observation of the flo and debris where the along the entire leng observation of the lo	oor on 400 hall revealed dirt e floor meets the baseboards					
	on 12/05/19 at 9:20 cleaning schedule for needed to be cleaned on stripping and way gotten around to it. Supervisor stated the and wax the floor on the stated he had tall about painting the w	e Housekeeping Supervisor AM revealed there was no or the baseboards but they ed. He stated he had planned king the floors but he had not The Housekeeping e floors were usually stripped ce a year close to Christmas. ked with the Administrator alls but he had not gotten to it t picked out a color yet.					
	9:22 AM revealed sh Housekeeping Supe walls on 300 and 40 picked out a color ye	e Administrator on 12/05/19 at the had talked with the rvisor about painting the 0 halls but they had not et. She stated the had not gotten around to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
	345305	B. WING			C 12/05/2019
NAME OF PROVIDER OR SUPPLIE	₹		STREET ADDRESS, CITY, STATE, ZIP CO	DE	12/00/2010
OMORAL DIDOE LIEAL TILLO DI	- IIA BII ITATION		310 PENSACOLA ROAD		
SMOKY RIDGE HEALTH & RI	HABILITATION		BURNSVILLE, NC 28714		
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA	5.475
in the process of 400 hall into a m focused on getting	bring the floor because they were trying to get a grant to turn the emory care unit and they were ng the grant instead of the floors.	F 5			4/0/00
F 641 Accuracy of Asso SS=D CFR(s): 483.20(F 64	41		1/2/20
The assessment resident's status This REQUIREM by: Based on record facility failed to a Data Set (MDS) prognosis (Resident #6). Findings include 1. Resident #74 08/14/18 with dia A review of a Hoeffective date of 08/23/19 signed indicated Reside a life expectancy diagnosis of mal tissue) of prostat A review of a Howith effective data 11/21/19 signed indicated Resided a lifective data 11/21/19 signed indicated Resided ind	d review and staff interviews the ccurately code the Minimum in area of Hospice to reflect lent #74 and #27) and area of creening and Resident Review lect Level II determination for d: was admitted to the facility on agnosis of cancer. spice Certification Statement with 05/26/19 and ending date of by the physician on 06/06/19 and #74 had a terminal illness with of six months or less for ignant neoplasm (new growth		(1)The facility failed to accurate Minimum Data Set (MDS Hospice to reflect prognosis #74 and #27) and area of Pr Screening and Resident Rev (PASARR) to reflect Level II for (Resident #6). Proper do obtained from Hospice entiti and MDS were modified to cof section J and O and result Corrections were provided to 12/3/19 day of resubmission Preadmission Screening and Review (PASARR) Section A #6 was modified and resubn Corrections provided to surve day of resubmission. Clinica Educator began in-servicing nursing staff 12/3/19 and co 12/18/19 to ensure complian policy and expectations were to correct coding of sections of the MDS. All Hospice recited Level II PASARR patient □s reviewed to ensure proper compliance.	S) in area of (Resident readmission view determinat ocumentation ies 12/3/19 correct codin bmitted. The consurveyors of the consurveyors of the desident of the codin test of	f n tion ng ng s nt 19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		345305	B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER		B: Wii(0		TREET ADDRESS CITY STATE ZID CODE	12	/05/2019	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SMOKY R	IDGE HEALTH & RE	HABILITATION			IO PENSACOLA ROAD			
				В	URNSVILLE, NC 28714			
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F 641	Continued From	nage 8	F	641				
	1	gnant neoplasm of prostate.		, ,				
	ulagriosis of mail	griant neoplasm of prostate.			(2)All residents with Hospice terminal			
	A review of 2 sen	arate significant change MDS			diagnosis and Level II PASARR have	rhe		
	· ·	ed 06/06/19 and 11/08/19			potential to be affected. An initial audi			
		Section J1400 Prognosis that			all active resident MDS and care plans			
		s not coded as having a chronic			reviewed and updated as indicated for			
		th result in life expectancy of			residents with Hospice services and Lo			
	less than 6 month	• •			II PASARR.			
		38 PM an interview was			(3)DON/ADON & SDC began immedia			
		IDS Nurse #1 who stated she			in-servicing on 12/3/19 and educations			
			were completed on 12/18/19 for licens					
		sident #74's significant change			nursing staff related to the procedure a			
		t dated 06/06/19 and 11/08/19.			expectation regarding proper coding o			
		evealed she did not code that did a life expectancy of less than 6			the MDS to ensure documentation and follow-up are met. DON/Designee will			
		the Hospice Certification for			audit MDS□ prior to submission to ens			
		e MDS dated 06/06/19 and			correct coding of section A, J, O is	uic		
		cation for significant change			reflected on the MDS and documentat	ion		
	1	t dated 11/08/19 were not			is present as indicated. Results of the			
	available in the m	nedical record when she			audit will be taken to QAPI meeting to			
	completed the as	sessment. MDS Nurse #1			evaluate compliance. DON/designee v	vill		
	revealed a modifi	cation of the significant change			complete audit of MDS for accuracy of	:		
		t dated 06/06/19 and 11/08/19			coding 5 x a week x 4 weeks, weekly x			
		submitted to accurately reflect			weeks then monthly x 3. Each licensed			
		d a life expectancy less than 6			nursing staff hired after this date will be	Э		
	months.				provided with a signed education			
	0:- 40/00/40 -+ 0:	00 DM i-4i			regarding policy and expectation relate	∌d		
		:09 PM an interview was IDS Nurse #2 who revealed she			to clinical documentation and follow t through to reflect accuracy of the med	ical		
		ed with the interpretation of the			record to ensure compliance.	Cai		
		ment Instrument (RAI) manual			record to ensure compliance.			
		Section J1400 Prognosis. MDS			(4)DON/Designee will report findings for	or		
		d a modification of the			potential interventions and documenta			
		e MDS assessment dated			that may be required. Results of these			
	•	08/19 would need to be			reviews will be taken to the QAPI			
		urately reflect Resident #74 had			Committee meeting monthly to ensure			
		less than 6 months.			ongoing substantial compliance. The			
					results of compliance will be reviewed			

Facility ID: 923575

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		345305	B. WING _			C 2/05/2019
	ROVIDER OR SUPPLIER	BILITATION		STREET ADDRESS, CITY, STATE, ZIF 310 PENSACOLA ROAD BURNSVILLE, NC 28714		2/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 641	conducted with the I who stated her expesignificant change Mobeen accurately code had a life expectance DON indicated there the interpretation of Nurse #1 to code Sesignificant change Mo6/06/19 and 11/08/On 12/03/19 at 3:01 conducted with the Aber expectation was MDS assessments worded to reflect Resexpectancy less that Administrator stated coding of Section J1 MDS Nurse #2 mising manual for coding point indicated Resident #27 was 07/27/17 with Alzheir A review of a Hospic effective date of 09/12/11/19 signed by the indicated Resident #4 a life expectancy of diagnosis of Alzheim A review of a signific Set (MDS) assessmunder Section J1400 was not coded as her	PM an interview was Director of Nursing (DON) ectation was that the IDS assessments would have ed to reflect Resident #74 y less than 6 months. The emay have been confusion of the RAI manual for MDS ection J1400 Prognosis on the IDS assessment dated 19. PM an interview was administrator who indicated that the significant change would have been accurately ident #74 had a life in 6 months. The she felt the inaccurate 400 Prognosis was related to interpretation of the RAI rognosis. Is admitted to the facility on mer's dementia. The Certification Statement with 13/19 and ending date the physician on 09/19/19 et 7 had a terminal illness with six months or less for	F6	every month x 3 months and QAPI meeting, then quar meeting until resolved. The responsible for overall control of the facility will be in control of the fac	terly at QAPI he DON/ADON is mpliance.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345305	B. WING		C 12/05/2019
	ROVIDER OR SUPPLIER	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 310 PENSACOLA ROAD BURNSVILLE, NC 28714	12/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 641	Continued From pag	e 10	F 64	.1	
	was responsible for or Prognosis on Reside MDS assessment da revealed she did not a life expectancy of I the Hospice Certification available in the medicompleted the signification of the significant change with the Resident Assessment on how to code Sect Nurse #2 revealed a significant change M 09/25/19 would need accurately reflect Reflex expectancy less than on 12/03/19 at 2:47 conducted with the Expectancy less than on 12/03/19 at 2:47 conducted with the Expectancy less than on 12/03/19 at 2:47 conducted with the Expectancy DON indicated there the interpretation of the Nurse #1 to code Section Programme Management of the significant change Management of the	Nurse #1 who stated she coding Section J1400. Int #27's significant change ted 09/25/19. MDS Nurse #1 code that Resident #27 had less than 6 months because tion statement was not cal record when she cant change MDS lurse #1 revealed a gnificant change MDS lurse #1 revealed a gnificant change MDS lurse #1 revealed a gnificant change MDS lurse #2 revealed to be lely reflect Resident #27 had is than 6 months. PM an interview was Nurse #2 revealed she had the interpretation of the lat Instrument (RAI) manual from J1400. Prognosis. MDS modification of the los assessment dated to be submitted to sident #27 had a life in 6 months. PM an interview was birector of Nursing (DON)			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345305	B. WING _			C 1 2/05/2019	
	ROVIDER OR SUPPLIER	BILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 310 PENSACOLA ROAD BURNSVILLE, NC 28714		12/03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 641	conducted with the Aher expectation was MDS assessment wo coded to reflect Resi expectancy less than Administrator stated coding of Section J1 to the MDS Nurse #2 manual for coding proceedings of Section J1 to the MDS Nurse #2 manual for coding procedure and schizopers of the MDS Nurse #2 manual for coding procedure with the MDS dated 11/17/12 with diagnoral disorder and schizopers (PASARR) dated 11/17 The annual Minimum 01/09/19 indicated a which asked if Resid by a Level II PASAR serious mental illness or related condition. An interview was coron 12/04/19 at 1:30 I confirmed Resident and the MDS dated incorrectly. She state and that she would massessment. An interview was coron Nursing (DON) on 12 indicated that it was	PM an interview was administrator who indicated that the significant change ould have been accurately ident #27 had a life in 6 months. The she felt the inaccurate 400. Prognosis was related 2 misinterpretation of the RAI organisms. Admitted to the facility on obses that included anxiety ohrenia. Atted Resident #6 had a Level bening and Resident Review (26/18). In Data Set (MDS) dated "NO" to question A1500 dent #6 had been evaluated R and determined to have a s and/or intellectual disability anducted with MDS Nurse #1 PM. M	F 6	41			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345305	B. WING _			12/	05/2019
	ROVIDER OR SUPPLIER	BILITATION	BURNSVILLE, NC 28714 F DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		х			(X5) COMPLETION DATE
F 641	4:29 PM revealed that assessment was key that she expected as:	PASARR. Administrator on 12/04/19 at at that she felt the MDS ed incorrectly. She stated sessment documentation to	F	641			
F 690 SS=D	be accurate and corre Bowel/Bladder Incont CFR(s): 483.25(e)(1)	tinence, Catheter, UTI	F	690			1/2/20
	resident who is continuadmission receives simaintain continence is	cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical les such that continence is					
	ensure that- (i) A resident who entindwelling catheter is resident's clinical concatheterization was notinity in the catheterization was notinity in the catheter or is assessed for removas possible unless the demonstrates that catheter and (iii) A resident who is receives appropriate	con the resident's assment, the facility must been the facility without an not catheterized unless the addition demonstrates that ecessary; ters the facility with an assubsequently receives one val of the catheter as soon the resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore the ent possible.					

PRINTED: 01/06/2020 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		, ,	E SURVEY IPLETED
	345305	B. WING _		12	C 2/05/2019
	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 310 PENSACOLA ROAD BURNSVILLE, NC 28714	,	100/2010
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. •		F 6	90		
comprehensive asseensure that a resider receives appropriate restore as much nor possible. This REQUIREMEN' by: Based on observation hospice nurse, and rethe facility failed to scatheter tubing for 1 hospice (Resident #77 hospice) (Resident #77 hospice) Resident #74 was accompostatic hypertrophy. A significant change assessment dated 1: #74 was cognitively independent for transform hygiene, and require. A review of Resident date of 11/08/19 add which indicated Resilurinary catheter relationstructive uropathy prostate cancer. The would have no injury manipulation. The appropriate to change catheter to thigh to publing.	ssment, the facility must at who is incontinent of bowel treatment and services to mal bowel function as T is not met as evidenced on, record review, staff, aurse practitioner interviews ecure indwelling urinary of 2 residents reviewed for 74). d: dmitted to the facility on uses of cancer and benign of (BPH). Minimum Data Set (MDS) 1/08/19 indicated Resident mpaired, was total ers, toileting, personal dan indwelling catheter. #74's care plan with revision ressed a urinary problem dent #74 had an indwelling and to diagnoses of BPH, (urinary disease), and a goal specified Resident #74 secondary to catheter proaches indicated staff eter every month and secure revent pulling on catheter		urinary catheter tubing for 1 of 2 reviewed for hospice (Resident #7 securing device obtained and place 12/3/19 to thigh of resident # 74 to injury secondary to catheter manipulated in-servicing to nursing staff 12/3/1 completed 12/18/19 to ensure conwith policy and expectations were related to Catheter Care policy and procedure. All residents with catheter securing device to ensure compliance. (2)All residents with indwelling Folicatheters have the potential to be affected. A review of all active residents with indwelling Foley catheters were reviewed and replaced as indicate residents with indwelling Foley carequiring leg securing device to prinjury secondary to catheter manipulated and modereflect use or refusal of catheters sedevice. (3)DON/ADON & SDC began immediated and policy in the securior of the segment of the securior of	esidents 74). Leg ced o prevent pulation. or began 9 and mpliance met; od eters of e ley sidents ere ed for theters revent pulation. ng Foley lified to ecuring	
An interview was cor	nducted on 12/02/19 at 3:28		in-servicing on 12/3/19 and 100%	of	
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR DATE OF THE PROPERTY OF THE PR	A significant change Minimum Data Set (MDS) assessment dated 11/08/19 indicated Resident #74 was admitted to the facility on 08/14/18 with diagnoses of cancer and benign prostatic hypertrophy (BPH). A significant change Minimum Data Set (MDS) assessment dated 11/08/19 addressed a urinary problem which indicated Resident #74 had an indwelling urinary catheter related to diagnoses of BPH, obstructive uroather were to change catheter every month and secure catheter to thigh to prevent pulling on catheter using catheter related to diagnoses of BPH, obstructive urong the process of the pr	CORRECTION 345305 B. WING B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, hospice nurse, and nurse practitioner interviews the facility failed to secure indwelling urinary catheter tubing for 1 of 2 residents reviewed for hospice (Resident #74). The findings included: Resident #74 was admitted to the facility on 08/14/18 with diagnoses of cancer and benign prostatic hypertrophy (BPH). A significant change Minimum Data Set (MDS) assessment dated 11/08/19 indicated Resident #74 was cognitively impaired, was total dependent for transfers, toileting, personal hygiene, and required an indwelling catheter. A review of Resident #74's care plan with revision date of 11/08/19 addressed a urinary problem which indicated Resident #74 had an indwelling urinary catheter related to diagnoses of BPH, obstructive uropathy (urinary disease), and prostate cancer. The goal specified Resident #74 would have no injury secondary to catheter manipulation. The approaches indicated staff were to change catheter every month and secure catheter to thigh to prevent pulling on catheter tubing.	A BUILDING 345305 B VINING STREET ADDRESS, CITY, STATE, ZIP CODE 310 PENSACOLA ROAD BURNSVILLE, NC. 28714 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPOIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 Incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, hospice nurse, and nurse practitioner interviews the facility failed to secure indwelling urinary catheter tubing for 1 of 2 residents reviewed for hospice (Resident #74). The findings included: Resident #74 was admitted to the facility on 08/14/18 with diagnoses of cancer and benign prostatic hypertrophy (BPH). A significant change Minimum Data Set (MDS) assessment dated 11/08/19 indicated Resident #74 was cognitively impaired, was total dependent for transfers, toileting, personal hygiene, and required an indwelling catheter. A review of Resident #74's care plan with revision date of 11/08/19 addressed a urinary problem which indicated Resident #74 had an indwelling urinary catheter related to diagnoses of BPH, obstructive uropathy (urinary disease), and prostate cancer. The goal specified Resident #74 would have no injury secondary to catheter manipulation. The approaches indicated staff were to change catheter every month and secure catheter to thigh to prevent pulling on catheter tubing. (3)DON/ADON & SDC began imm	A BUILDING 345305 B. WING 345305 B. WING 345305 B. WING 35TREETADDRESS, CITY, STATE, ZIP CODE 310 PENACOLA ROAD BURNSVILLE, NC 28714 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, hospice nurse, and nurse practitioner interviews the facility failed to secure indwelling urinary catheter tubing for 1 of 2 residents reviewed for hospice (Resident #74). Leg securing device obtained and placed 12/3/19 to thigh of resident #74 to prevent injury secondary to catheter manipulation. The findings included: Resident #74 was admitted to the facility on 08/14/18 with diagnoses of cancer and benign prostatic hypertrophy (BPH). A significant change Minimum Data Set (MDS) assessment dated 11/08/19 indicated Resident #74 was cognitively impaired, was total dependent for transfers, tolleting, personal hygiene, and required an indwelling catheter. A review of Resident #74's care plan with revision date of 11/08/19 addressed a urinary problem which indicated Resident #74 had an indwelling catheter. A review of Resident #74 had an indwelling urinary catheter related to disheter Care policy and procedure. All residents with catheters were revelued and replaced as indicated for residents with indwelling Foley catheters were reviewed and replaced as indicated for residents with indwelling Foley catheters were requiring leg securing device to review and replaced as indicated for residents with indwelling Foley catheters were reviewed and replaced as indicated for residents with indwelling Foley catheters were reviewed and modified to reflect use or refusal of catheter securing device. (2)All residents with indw

Facility ID: 923575

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	, ,	DATE SURVEY COMPLETED
			D. WING			С
		345305	B. WING			12/05/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SMOKY R	INGE HEALTH & REHAR	RII ITATION		310 PENSACOLA ROAD		
SMOKY RIDGE HEALTH & REHABILITATION			BURNSVILLE, NC 28714			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 690	Continued From page	e 14	F 69	0		
F 690	PM with Nurse Aide (#74 did not have a ca his thigh. NA #1 state catheter tubing secur thigh to prevent pullir On 12/03/19 at 3:30 If conducted with of Nu Resident #74 which in not have a catheter is his thigh to prevent p Resident #74 did not bleeding from the ure related to the absence device. Nurse #1 indi have had a catheter is On 12/03/19 at 3:59 If conducted with the Ti stated per the treatme (TAR) Resident #74's were to be changed in changing the cathete stated it was the resp catheter securing dev Resident #74's cathe Resident #74's cathe Resident #74's cathe Resident #74 should securing device to pri tubing and the securi TN indicated Resider tubing securing device applied a catheter tub On 12/03/19 at 4:08 If conducted with the D	NA) #1 who stated Resident atheter securing device on ed she had never applied a ing device to Resident #74's ag on the catheter tubing. PM an observation was rese #1 while she assessed revealed Resident #74 did recuring device in place on ulling on the catheter tubing. have any observed signs of ethral meatus (opening) re of catheter securing cated Resident #74 should recuring device. PM an interview was reatment Nurse (TN) who rent administration record a catheter bag and tubing monthly which included recuring device. The TN reconsibility of the TN to assure vice was in place to secure ter tubing. The TN indicated have had a catheter revent pulling on the catheter revent pulling on the catheter received was missed. The ent #74 wanted a catheter receive and the TN immediately bring securing device.	F 69	educations completed on 12/1 licensed and non-licensed nu related to the procedure and eregarding proper catheter care placement of catheter securing prevent injury secondary to camanipulation are met. DON/D audit placement of catheter sedevice placement as indicated residents with indwelling Foley Results of the audit will be tak meeting to evaluate compliant DON/designee will complete a catheter securing device for the use of indwelling Foley catheter week x 4 weeks, weeks, week weeks then monthly x 3. Each nursing staff hired after this daprovided with a signed educat regarding policy and expectati to catheter care and leg secur placement to ensure compliant (4)DON/Designee will audit casecuring device placement as for residents with indwelling For catheters for potential interver documentation that may be recatheters for potential interver documentation that may be recat	rsing staff expectation and g device to theter resignee will ecuring for r catheters. en to QAPI ce. rudit of rose with ers 5x a ly x 4 licensed ret will be ret will be ret indicated bley ritions and quired. e taken to monthly to mpliance. be reviewed e monthly at QAPI	
	#74 would have had	a catheter tubing securing icy. The DON indicated it		01/02/2020.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	' '	SURVEY PLETED
		345305	B. WING			C / 05/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 12	105/2019
				310 PENSACOLA ROAD		
SMOKY RIDGE HEALTH & REHABILITATION				BURNSVILLE, NC 28714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILITION DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	place to prevent pullir tubing. The DON state failed to monitor that tubing securing device. On 12/03/19 at 4:40 F conducted with the Adexpectation was that had an indwelling cat to prevent pulling on policy. The Administrators missed checking had a catheter tubing. On 12/04/19 at 8:41 Advanced with the was conducted with the was conducted with the who stated her expect #74 would have a cat in place to prevent put the NP stated even with the policy.	atheter securing device in any on the indwelling catheter ed the treatment nurse Resident #74 had a catheter e. PM an interview was administrator who stated her Resident #74 would have the ter tubing securing device catheter tubing per facility ator stated the treatment any to assure Resident #74 securing device. AM a telephone interview the Nurse Practitioner (NP) station was that Resident the ter tubing securing device with a securing device in	F	590		
F 761 SS=D	place the catheter tubing the securing device with the securing device with the catheter tubing. On 12/04/19 at 9:05 A was conducted with the expectation was thave a catheter tubing prevent pulling of cath Label/Store Drugs and CFR(s): 483.45(g)(h) §483.45(g) Labeling of Drugs and biologicals	AM a telephone interview the hospice nurse who stated that Resident #74 would g securing device in place to the neter tubing. d Biologicals (1)(2) of Drugs and Biologicals a used in the facility must be the with currently accepted s, and include the	F	761		1/2/20

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345305	B. WING		C 12/05/2019
	ROVIDER OR SUPPLIER	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 310 PENSACOLA ROAD BURNSVILLE, NC 28714	1 12/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 761		ge 16 expiration date when	F 76	1	
	supplicable. §483.45(h) Storage	of Drugs and Biologicals			
	Federal laws, the factoriologicals in locked	cordance with State and collity must store all drugs and compartments under proper s, and permit only authorized coess to the keys.			
	locked, permanently storage of controlled the Comprehensive Control Act of 1976 abuse, except when package drug distrib quantity stored is mi be readily detected. This REQUIREMEN	acility must provide separately affixed compartments for I drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit oution systems in which the nimal and a missing dose can			
	facility failed to date tuberculin purified pi was available for us	ervations and staff interviews the date an opened multi-use bottle of fied protein derivative (PPD) that for use in 1 of 2 medication oserved for medication storage.		(1)The facility failed to date an op multi-use bottle of tuberculin purific protein derivative (PPD) that was available for use in 1 of 2 medicati refrigerators observed for medicati storage. The PPD vial was immed discarded in appropriate receptacl removed from use. Staff Developn	ed ion ion iately e and
	refrigerator on 12/04 opened but undated bottle of PPD solution An interview with the (ADON) on 12/04/19 ml bottle of PPD sol	e North medication room 1/19 at 4:13 PM revealed an multi-use 1 milliliter (ml) on. e Assistant Director of Nursing 0 at 4:13 PM revealed the 1 ution should have been dated . The ADON stated the		Nurse Educator began in-servicing nursing staff 12/4/19 and complete 12/18/19 to ensure compliance wit and expectations were met; related labeling and storage of medication policy and procedure. Both medical storage rooms were re-evaluated the ensure compliance.	g to ed th policy d to ns

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	' '	DATE SURVEY COMPLETED
		345305	B. WING _			C 12/05/2019
NAME OF PROVIDER OR SUPPLIER SMOKY RIDGE HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 310 PENSACOLA ROAD		12.00.2010		
			BURNSVILLE, NC 28714			
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F 761	Continued From page	e 17	F 7	61		
F 761	Continued From page 17 Nurse Supervisors checked the medication carts, medication refrigerators, and medications weekly and the medication refrigerator was last checked 12/02/19. An interview with the Director of Nursing (DON) on 12/05/19 at 9:58 AM revealed the PPD solution should have been dated when it was opened. She stated the process for checking for expired or undated medications weekly and the medication refrigerators, and medication carts, medication refrigerators, and medication rooms for expired or undated medications was for the Nurse Supervisors to check the medication rooms for expired or undated medications weekly and the medication refrigerators, and medication rooms for expired or undated medications weekly and the medication refrigerator was last checked the morning of 12/02/19. The DON said the undated bottle of PPD solution was just overlooked when the mediation refrigerator was checked on 12/02/19. An interview with the Administrator on 12/05/19 at 9:59 AM revealed she expected the nurse who opened the bottle of PPD solution to have dated the medication at the time it was opened or the person assigned to check the medication refrigerator to have either dated or discarded the medication.			(2)All residents receiving PPD have the potential to be advers affected. A review of medication rooms were re-evaluated to encompliance met with labeling a of medications. (3)DON/ADON & SDC begand in-servicing on 12/4/19 and 10 educations completed on 12/1 licensed nursing staff related to and storage of medications procedure. DON/Designee will medication storage locations. It the audit will be taken to QAPI evaluate compliance. DON/descomplete audit 5x a week x 4 weekly x 4 weeks then monthly licensed nursing staff hired aftiwill be provided with a signed regarding policy and expectation to labeling and storage of medication rooms for labeling of medications monthly x 3, for interventions and documentation be required. Results of these repetitions are decompliance. The results of combe reviewed every month x 3 repetitions and the provided compliance. The results of combe reviewed every month x 3 repetitions and the provided compliance. The results of combe reviewed every month x 3 repetitions and the provided compliance. The results of combe reviewed every month x 3 repetitions and the provided compliance. The results of combe reviewed every month x 3 repetitions and the provided compliance. The results of combe reviewed every month x 3 repetitions and the provided compliance. The results of combe reviewed every month x 3 repetitions and the provided compliance. The results of combe reviewed every month x 3 repetitions and the provided compliance. The results of combe reviewed every month x 3 repetitions and the provided compliance. The results of combe reviewed every month x 3 repetitions and the provided compliance.	sely on storage on storage and storage and storage simmediate 0% of 18/19 for o labeling blicy and a laudit Results of meeting to signee will weeks, y x 3. Each er this date education on related lications to audited and storage or potential on that may reviews will be meeting betantial mpliance will months at en quarterly l.	

		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345305	B. WING		C 12/05/2019
	ROVIDER OR SUPPLIER	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 310 PENSACOLA ROAD BURNSVILLE, NC 28714	12/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 867 F 867 SS=D	Continued From page QAPI/QAA Improvem CFR(s): 483.75(g)(2) \$483.75(g) Quality as \$483.75(g)(2) The quassurance committee (ii) Develop and implaction to correct iden This REQUIREMENT by: Based on record reviacility's Quality Asse (QAA) committee fail procedures and mon committee had previate annual recertification was for one recited dicited in November 20 on the current recertiinvestigation of 12/05 was in the area of accontinued failure of the surveys of record she	e 18 nent Activities (ii) ssessment and assurance. uality assessment and	F 86	DEFICIENCY)	t and d teee g the at and ation n the
	Minimum Data Set (No reflect prognosis (Re	ord review and staff failed to accurately code the MDS) in area of Hospice to sident #74 and #27) and n Screening and Resident o reflect Level II		Screening and Resident Review (PASARR) to reflect Level II determin for (Resident #6). The MDS for resident #74, #27, and #6 were modified and resubmitted after corrections made to MDS. Regional Director of Operations in-serviced LNHA and DON 12/11/19 interdisciplinary team 12/12/19 to ensempliance with policy and expectation were met; related to QAPI/QAA to encompliance.	ents the and sure ons

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345305	B. WING			1	C
	ROVIDER OR SUPPLIER		B. WING	STF 310	REET ADDRESS, CITY, STATE, ZIP CODE D PENSACOLA ROAD JRNSVILLE, NC 28714	<u> 12/</u>	05/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	11/16/18 the facility waccurately code the ILevel II PASRR dete identified as PASRR 12/05/19 at 10:24 AM with the Administrato process in place to mPASRR Level II dete improved so the over The Administrator shadetermination was ju	certification survey of was cited for failure to MDS assessment to reflect rmination for a resident	F		(2)All residents have the potential to be adversely affected in the area of accura of assessments. (3)The Administrator and Director of Nursing were educated by the Regional Director of Operations on the facilities Quality Assurance Performance Improvement program (QAPI) on 12/11/19. The education included identifying areas of continuous quality monitoring and the tools to be used. The Director of Nursing educated facilities interdisciplinary team 12/12/19 regarding the policy and procedures on the QAPI program. Education also included monitoring activities, a focus on the processes that effect resident outcome and performance improvement. Ongoin monitoring will be used to re-establish the facilities outcomes. DON/ADON & SDC began immediate in-servicing on 12/5/1/18/19 for licensed nursing staff related QAPI/QAA policy and procedure. The Administrator is accountable for the overall implementation and functioning 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 plate and monitoring the effectiveness of successions. The Regional Director of Operations (RDO) will review the facility QAPI Committee meeting minutes for uto six months to ensure ongoing compliance.	acy all ae ag the ag the ar ans ch	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345305	B. WING _			l	05/2019
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	12-7	00/2010
				310	PENSACOLA ROAD		
SMOKY R	IDGE HEALTH & REHAB	BILITATION			RNSVILLE, NC 28714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	⊋ 20	F		(4)The QAPI committee will meet mont to continue to monitor and identify area of improvement to include survey deficiencies. The Committee will addre the identified needs through improvem action plans and monitoring the effectiveness of such plans. The Regio Director of Operations(RDO) will review the facility QAPI Committee meeting minutes for up to six months to ensure ongoing compliance. (5) The facility will be in compliance as 01/02/2020.	ss ss ent, nal	