STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345305	A. BUILDING _____ B. WING _____	C 03/20/2024

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

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 03/20/24. Event ID# ILT811. The following intakes were investigated: NC00212924, NC00213236, and NC00214095. One (1) of the 18 complaint allegations resulted in a deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and resident, Family Member, and staff interviews, the facility failed to protect the resident's right to be free from employee to resident abuse for 1 of 3 residents reviewed for abuse (Resident #1). Nurse #1 reported that Resident #1 hit Nurse Aide (NA) #1 in the face while she was providing care to him. Nurse #1 observed NA #1 grab Resident #1's arm and push it towards his stomach and hold it there while leaning in Resident #1 face and saying, "don't you ever hit me again, do you understand?". Three days after the incident	F 600	For affected resident(s): Resident #1, had complete exams by the Nurse Practitioner on 1/31/24, 3/28. The Registered Nurse and License Practical Nurse completed full skin assessments for resident #1, weekly on 2/1, 2/8, 2/15, 2/22, 2/29, 3/7, 3/14, 3/21, 3/28, 4/4/24 and weekly thereafter. How corrective action will be accomplished for resident(s) having the	4/5/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/09/2024

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F 600	Continued From page 1 Resident #1 was observed to have a small round circular bruise on top of his right forearm and a faded circular bruise on the side of his right forearm. A reasonable person would expect to be free from abuse in their own home and could experience anger, fear, anxiety, and depressed mood. The findings included: Resident #1 was admitted to the facility on 8/29/22 with diagnoses that included dementia. A quarterly Minimum Data Set (MDS) assessment dated 2/07/24 indicated Resident #1 was severely cognitively impaired, required extensive assistance for toileting and personal hygiene. No rejection of care or behaviors were noted on the MDS. A review of the Initial Allegation Report dated 1/31/24 revealed the facility was made aware of the alleged abuse incident involving Resident #1 and NA #1. The report indicated the facility began their investigation at this time, notified law enforcement and Department of Social Services (DSS), suspended NA #1 pending investigation. Review of Resident #1 skin assessment dated 1/31/24 revealed no new bruising to right arm. Review of a provider note dated 1/31/24 written by the Nurse Practitioner (NP) revealed she was requested to evaluate Resident #1's right arm for skin check. The NP noted Resident #1 was comfortable, calm, and in no acute distress. Resident #1 was able to move all extremities and there was no new bruising to right arm, no ecchymosis (common bruise), no lesions or	F 600	potential to be affected by the same issue: All residents have the potential to be affected by the alleged non-compliance. NA #1 was terminated on 3/20/24. The Director of Nursing conducted direct care observations for 100% of our cognitively impaired residents and was initiated on 3/21/24. The Director of Nursing then conducted direct care observations for all the remaining residents in the facility and was completed on 4/5/24. Education was provided by Vaya Health to all the nurses and CNAs on Dementia, Communication strategies, as well as de-escalation techniques. The Director of Nursing and Staff Development Nurse educated 100% of the nursing staff on the Abuse policy and Abuse reporting and completed on 4/5/24. What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: 1.The Director of Nursing or designee will educate all new employees on the Abuse policy to include abuse reporting, abuse investigation upon orientation and annually. 2.The Director of Nursing or designee will provide Dementia training as well as cognitively impaired de-escalation techniques. This education will be provided upon orientation and annually thereafter. 3.The Director of Nursing or designee will observe direct resident care observations with random residents on all shifts.	

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F 600	Continued From page 2 lacerations and the right arm was non-tender. Continue with monitoring and plans of care for Resident #1. Review of Resident #1 skin assessment dated 2/01/24 revealed no new bruising to right arm. Review of Investigation Report dated 2/1/24 completed by the Administrator for the allegations of abuse revealed "the incident occurred on 1/31/24 at 8:32 AM when Nurse #1 reported to Assistant Director of Nursing (ADON) that during a combative episode during activities of daily living (ADL) care she witnessed NA #1 in defense of being slapped in the face by Resident #1, in a moment reaction, NA #1 caught Resident #1 arm while attempting to slap her and moved his arm away from her face to his body and told him not to hit her again. NA #1 was suspended pending investigation. In conclusion, NA #1 inappropriately responded to situation but did not have ill will or malicious intent and acknowledges behavior. Allegation of abuse has been unsubstantiated as of 2/01/24 and NA #1 to return to work on 2/02/24 and made aware of facility findings." An observation of Resident #1 on 3/20/24 at 11:15 AM revealed him to appear clean, dressed and sitting up in his bed watching TV with no visible signs of bruising on his arms or hands. Resident #1 was not able to be interviewed about the incident but did respond when asked how he was doing, and he stated he was fine and smiled. A telephone interview with NA #1 on 3/20/24 at 3:42 PM revealed she was working on the morning of 1/31/24 when Nurse #1 had asked if she would come into Resident #1 room to assist with personal care. She stated Personal Care	F 600	Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: The Administrator, Director of Nursing or designee will monitor that the education on the Abuse policy, Dementia and Cognitively impaired de-escalation technique is done upon orientation and annually. An audit sheet will be done by the Director of Nursing or designee to monitor for compliance. The monitoring will be done with every new orientation x 6 months and with the annual education x 1. The Director of Nursing or designee will observe five direct resident care observation on all shifts. This process will take place (M-F), daily for 2 weeks, then weekly x 4, then monthly x 4 months. The Administrator, Director of Nursing or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 4/5/24.	

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Assistant (PCA) #1 was in the hall with her and she asked her to get the shower chair for Resident #1 since it was his shower day they could go ahead and get his shower out of the way. She revealed when she entered Resident #1 room he was sitting on the side of the bed with his brief, pants, and socks on and his socks appeared to be wet. NA #1 stated she bent over in front of Resident #1 and began removing his wet brief from around his ankles and while removing his socks he hit her in the face with his partially closed right hand. She revealed it happened so fast and she believed he might hit her again, so she just reacted and grabbed his wrist/forearm area and pushed it towards his stomach and told him not to ever hit her again and then moved herself back towards the closet. She stated the Personal Care Assistant (PCA) #1 came into the room after the incident had occurred and took Resident #1 for his shower, and he was compliant and did not appear to be in any distress. NA #1 revealed once Resident #1 had left the room she finished making his bed and that was when the ADON came and pulled her from the floor, and she was asked to give her statement about the incident and was sent home on suspension pending the investigation. She stated to her knowledge the investigation was unsubstantiated and she was allowed to return to work a couple of days later after completing training on dementia, abuse, and behavioral training. NA #1 revealed that she knew how she responded to Resident #1 was wrong, but everything happened so fast, and she didn't think she just acted, and it was human error.

A telephone interview with Nurse #1 on 3/20/24 at 4:42 PM revealed she was no longer employed at the facility but recalled the incident on 1/31/24

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that involved NA #1 and Resident #1. Nurse #1 indicated on the morning of 1/31/24, around breakfast time, she had gone into Resident #1 room and found him sitting on the side of the bed with his shirt on and his brief and pants were around his ankles and his socks appeared to be wet. She stated she went to the door of the room and requested assistance from NA #1 with removing Resident #1 clothing and providing personal care. Nurse #1 revealed NA #1 entered Resident #1 room to assist with care while PCA #1 went to retrieve a shower chair due to it being Resident #1 shower day. She stated NA #1 appeared "aggravated" when entering Resident #1 room and did not speak to Resident #1 or explain to him what she was going to do prior to removing his brief, pants, and socks. Nurse #1 stated she was standing by Resident #1's bedside and NA #1 was bent over at the waist in front of Resident #1 removing his brief and clothing when she observed Resident #1 hit NA #1 in the face with his partially closed right hand. She revealed NA #1 immediately grabbed Resident #1 right wrist/forearm and pushed it towards his stomach and held it there while she leaned into his face with gritted teeth and stated with a stern voice, "don't you ever hit me again, do you understand?" and then released Resident #1 and moved back towards the closet. Nurse #1 revealed after the incident, she observed Resident #1 to have a startled wide-eyed look on his face but did not answer when asked if he was ok and did not respond when Nurse #1 spoke with him about not hitting others. She stated PCA #1 returned and assisted Resident #1 who was compliant into the shower chair, and they left towards the shower room. She revealed NA #1 finished making Resident #1 bed. Nurse #1 stated she also left the room at this time and

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reported the incident to the ADON first and then to the Administrator and the Director of Nursing (DON) and provided her written statement. She stated she did not feel NA #1 was trying to cause Resident #1 any harm it was just a reaction to him hitting her, but they had been trained in how to handle resident behaviors and that you do not place your hands on residents or speak to them in that manner NA #1 spoke to Resident #1 and that is why she reported the incident to Administration. Nurse #1 stated she did not observe any bruising or red marks on Resident #1 after the incident and she continued to check on him throughout the day and he did not appear to be upset and was continuing with his normal routine. Nurse #1 revealed she had been off for two days following the incident and when she returned on 2/03/24 she did notice a small round bruise on top of Resident #1 right forearm and a faint looking round bruise on the side of his right forearm and she took a picture of the bruise and notified the Administrator.

An interview conducted with the ADON on 3/20/24 at 2:36 PM revealed she had been working on 1/31/24 and was familiar with the incident between NA #1 and Resident #1. She stated Nurse #1 had come to her the morning of 1/31/24, she believed around breakfast time, and informed her that she had gone into Resident #1 room and found him sitting on the side of the bed with his brief around his ankles and wet socks and she asked NA #1 for assistance with providing him personal care. She revealed Nurse #1 reported that while NA #1 was bent over removing Resident #1 socks he hit her in the face and NA #1 responded by pushing his arm down to his stomach then leaned into Resident #1's face and said, "don't you ever hit me again'. The

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ADON stated she and Nurse #1 informed the Administrator and Director of Nursing (DON) of the incident and NA #1 was immediately pulled from the floor and suspended pending investigation. She also stated interviews were completed with alert and oriented residents on the hall with no issues or concerns and skin assessments were completed with all residents including Resident #1 with no signs of any bruising or red marks noted. She revealed during the interview with NA #1, she stated that she knew what she had done was wrong and she should not have responded in that manner but was caught in the moment and reacted to being hit in the face. The ADON stated to her knowledge Resident #1 had resumed his regular routine and showed no signs of being upset or afraid and there had been no other incidents of him attempting to strike other staff. The ADON stated the investigation was unsubstantiated due to no ill intent from NA #1 to cause harm and she was allowed back to work after completing training on dementia, abuse policies, and behavioral training on how to respond to aggressive residents.

An interview with the Administrator and Director of Nursing (DON) on 3/20/24 at 5:40 PM revealed they learned of the confrontation between NA #1 and Resident #1 on 1/31/24 when the ADON and Nurse #1 reported it to them. They stated once they were notified of the incident, the ADON immediately removed NA #1 from the floor, and she was interviewed and then suspended pending investigation. They revealed due to Resident #1 cognition level he was not able to be interviewed but they completed interviews with alert and oriented residents on the hall and completed skin assessments on all residents

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F 600	Continued From page 7 including Resident #1 with no issues or concerns and no bruises noted. The DON stated she had checked on Resident #1 throughout 1/31/24 and the following day and he had resumed his normal schedule and did not appear show any signs of being afraid or upset. When asked about the pictures of the bruise on Resident #1 right forearm taken by Nurse #1 on 2/03/24, the Administrator nor the DON recall ever being informed of a bruise or seeing pictures of a bruise and or of staff reporting a bruise. The Administrator stated they did not substantiate the allegations because she did not feel NA #1 had intentions to cause harm to Resident #1 and the incident was simply a mistake and a momentary reaction to Resident #1 hitting NA #1 in the face.	F 600		