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	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smoky Ridge Health and Rehabilitation	310 Pensacola Road Burnsville, NC 28714

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of falls, medications received, and hospice for 4 of 21 residents reviewed for accuracy of MDS assessments (Resident #12, #7, #9 and #10). Findings included: 1. Resident #12 was admitted to the facility on [DATE]. A nurse's progress note revealed on 5/11/26, Resident #12 was found sitting on the floor beside the bed and reported he tried to get up and fell. Resident #12's vital signs and range of motion were assessed as being within normal limits, there were no visible signs of an injury, and he was assisted back to bed. A review of discharge MDS assessment dated [DATE] coded for falls since admission/entry or reentry or the prior assessment indicated Resident #12 had no falls. A joint interview with MDS Coordinator #1 and MDS Coordinator #2 was conducted on 06/26/26 at 11:34 AM. MDS Coordinator #1 stated Resident #12's fall on 5/11/26 should have been coded on the discharge assessment dated [DATE] to show one fall with no injury had occurred. She revealed the assessment was completed by remotely by MDS Coordinator #2. MDS Coordinator #2 confirmed she completed the section for falls on Resident #12's discharge MDS assessment dated [DATE]. She was unsure why the fall that occurred on 5/11/26 was not coded and stated it was an oversight on her part. MDS Coordinator #1 stated she would modify the assessment to show Resident #12 had one fall with no injury on the discharge MDS assessment dated [DATE]. During an interview on 06/26/26 at 1:43 PM, the Director of Nursing (DON) stated MDS coding should be correct and reflect the status of the resident at the time of the assessment. During an interview on 06/26/26 at 1:48 PM, the Administrator revealed the facility utilized two remote MDS Coordinators. She explained the MDS Coordinators had access to residents' electronic medical records and stated the MDS should be coded correctly to reflect the status of the resident at the time of the assessment. 2. Resident #7 was admitted to the facility on [DATE]. A review of an incident note dated 9/30/25 revealed Resident #7 had an unwitnessed fall and was noted to have a hematoma on her forehead and bridge of the nose with two small lacerations. (continued on next page)

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.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Nurse Practitioner (NP) progress note dated 10/1/25 revealed Resident #7 was assessed for a fall that occurred when she tried to get up from a wheelchair. The NP's assessment noted Resident #7 was alert and oriented with no evidence of head trauma or acute distress and there was no indication for lab work or imaging. No new physician orders were provided and the NP recommended to continue monitoring Resident #7. A review of the annual MDS assessment dated [DATE] coded for falls since admission/entry or reentry or the prior assessment indicated Resident #7 had one fall with a major injury. A joint interview with MDS Coordinator #1 and MDS Coordinator #2 was conducted on 06/26/26 at 11:34 AM. MDS Coordinator #2 stated she thought a hematoma was considered as a major injury and why she coded Resident #7's annual MDS assessment dated [DATE]. MDS Coordinator #1 stated a hematoma was not classified as a major injury on the MDS assessment for falls. MDS Coordinator #1 stated the fall occurred on 9/30/25 and the injuries documented were a hematoma on the top of the nose and forehead with two small lacerations and should be coded as fall with injury but not major. During an interview on 06/26/26 at 1:43 PM, the DON stated MDS coding should be correct and reflect the status of the resident at the time of the assessment. During an interview on 06/26/26 at 1:48 PM, the Administrator revealed the facility utilized two remote MDS Coordinators. She explained the MDS Coordinators had access to residents' electronic medical records and stated the MDS should be coded correctly to reflect the status of the resident at the time of the assessment. 3. Resident #9 was admitted to the facility on [DATE]. A review of Resident #7's physician orders included inject 0.1 milliliter tuberculin purified protein derivative (PPD) one time only dated 5/13/26 and ceftriaxone (antibiotic) 1 gram intramuscularly (IM) one time a day for 4 days for a urinary tract infection dated 5/14/26. There was no physician order for insulin from 5/1/26 through 5/30/26. A review of Resident #9's medication administration record (MAR) revealed nurses initialed tuberculin 0.1 milliliter was administered once at 3:24 PM on 5/13/26 and ceftriaxone 1 gram IM was administered at 2:00 PM on 5/14/26, 5/15/26, 5/16/26, and 5/17/26. There were no insulin injections administered from 5/1/26 through 5/30/26. A review of Resident #9's quarterly MDS assessment dated [DATE] indicated the number of days that injections of any type were received during the last 7 days as five (5) and record the number of days that insulin injections were received during the last 7 days as four (4). A joint interview with MDS Coordinator #1 and MDS Coordinator #2 was conducted on 06/26/26 at 11:48 AM. MDS Coordinator #2 confirmed she had mistakenly coded Resident #9's quarterly MDS dated [DATE] as having received insulin injections and was an error on her part. MDS Coordinator #1 stated Resident #9 did not receive insulin injections but did receive 5 injections and explained (4) IM antibiotic injections and (1) tuberculin PPD test were administered during the 7-day lookback period. During an interview on 06/26/26 at 1:43 PM, the DON stated MDS coding should be correct and reflect the status of the resident at the time of the assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/26/26 at 1:48 PM, the Administrator revealed the facility utilized two remote MDS Coordinators. She explained the MDS Coordinators had access to residents' electronic medical records and stated the MDS should be coded correctly to reflect the status of the resident at the time of the assessment. 4. Resident #10 was admitted to the facility 04/12/01. A Notification of admission to Hospice form revealed Resident #10 elected hospice services effective 06/11/24. The significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had a condition or chronic disease that may result in a life expectancy of less than six months and he was not receiving hospice care. During an interview on 06/25/26 at 12:55 PM, MDS Coordinator #1 verified that Resident #10 currently received hospice services and had been since 06/11/24. MDS Coordinator #1 stated the significant change MDS assessment should have reflected Resident #10 received hospice care and it was an oversight. During an interview on 06/26/26 at 12:40 AM, the Administrator stated she expected for all MDS assessments to be completed accurately.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) reevaluation after a significant change in physical or mental status was identified for a resident previously determined to have a Level II PASRR. This deficient practice affected 1 of 2 sampled residents reviewed for PASRR (Resident #90).Findings included:Resident #90 was admitted to the facility on [DATE]. Her cumulative diagnoses included anxiety disorder, bipolar disorder, depression, and Post-traumatic Stress Disorder (PTSD).A PASRR Level II Determination Letter dated 12/08/23 revealed Resident #90 had a Level II PASRR with no effective date and nursing facility placement was appropriate.A significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 was considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. Resident #90's active psychiatric/mood disorder diagnoses included anxiety disorder, depression, bipolar disorder, and PTSD. She received antipsychotic, antidepressant and antianxiety medications during the MDS assessment period.Review of Resident #90's medical record revealed no evidence a request for a Level II PASRR reevaluation was submitted following the significant change MDS assessment dated [DATE].During interviews on 06/25/26 at 12:25 PM and 06/26/26 at 12:28 PM, MDS Coordinator #1 confirmed she was the person responsible for submitting requests for Level II PASRR reevaluations, including after a resident had a significant change in condition identified. MDS Coordinator #1 confirmed she did not submit a request for a Level II PASRR reevaluation following Resident #90's significant change MDS assessment dated [DATE]. She stated it was an oversight.During an interview on 06/26/26 at 12:40 PM, the Administrator stated requests for Level II PASRR reevaluations should be made when a resident had a significant change in condition per the regulatory guidelines.