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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345447 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/24/2011 |
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| NAME OF PROVIDER OR SUPPLIER EMERALD RIDGE REHAB AND CARE C | STREET ADDRESS, CITY, STATE, ZIP CODE 25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804 |
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| (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 |
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| F 156 SS=B | <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting</p> | F 156 | <p>Emerald Ridge Rehab and Care Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary findings are factually correct and in order to maintain compliance with applicable rules and provision of quality care of residents. The plan of correction is submitted as written allegation of compliance.</p> <p>Emerald Ridge Rehab and Care Center's response to the Statement of Deficiencies and plan of correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate.</p> <p>Emerald Ridge Rehab and Care Center reserves the right to submit documentation or refute any of the stated deficiencies on the Statement of Deficiencies through the informal dispute resolution, formal appeal procedure and/or any other legal or administrative proceeding.</p> <div style="text-align: center; border: 1px solid blue; padding: 5px; width: fit-content; margin: 10px auto;"> <p>RECEIVED</p> <p>APR 15 2011</p> <p>BY: <i>MH</i></p> </div> | 4/22/11 |
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|---|-------------------------------------|-----------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ✓ <i>Thomas S. Hager</i> | TITLE ✓ <i>Administrator</i> | (X6) DATE ✓ <i>4/15/11</i> |
|---|-------------------------------------|-----------------------------------|

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 156 | <p>Continued From page 1</p> <p>personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and</p> | F 156 | <p>All residents that reside in this building with a payor source of Medicare A are at risk to be affected by this practice.</p> <p>Education to the MDSC and BOM regarding proper time for notification of discontinuation of Medicare A coverage will be provided by the DON and BOM consultant.</p> <p>Audits will be conducted on ALL Medicare A, Medicare Replacement, and Medicare B notifications of discontinuance for timeliness. This will be done by ADON/DON and designee. This audit will be reviewed and reported to the QI/QA committee monthly x 12 months.</p> | |

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| F 156 | <p>Continued From page 2 applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interviews the facility failed to provide a written two day notice for the discontinuation of Medicare benefits for three (3) of three (3) sampled residents. (Residents #5, 21, 22)</p> <p>The findings are:</p> <ol style="list-style-type: none"> Review of the Notice of Medicare Provider Non-Coverage, CMS form 10123, revealed a notice dated 3/18/11 to Resident #5, which stated current Medicare services would end on this date. A continued review of the notice revealed a signature indicating the responsible party for Resident #5 received the notice on 3/18/11. <p>An interview on 3/24/11 at 11:09AM with the Director of Nursing (DON) revealed she verbally notifies the resident or responsible party 5 days prior to the termination of Medicare benefits. She then completes the written notification for termination of Medicare benefits and obtains a</p> | F 156 | | |

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| F 156 | <p>Continued From page 3</p> <p>signature from the resident or responsible party on the day benefits are ending. The DON stated the written notice for discontinuation of Medicare benefits should be submitted to the resident or responsible party two days prior to termination of Medicare coverage.</p> <p>2. Review of the Notice of Medicare Provider Non-Coverage, CMS form 10123, revealed a notice dated 3/04/11 to Resident #21, which stated current Medicare services would end on this date. A continued review of the notice revealed a signature indicating the responsible party for Resident #21 received the notice on 3/04/11.</p> <p>An interview on 3/24/11 at 11:09AM with the Director of Nursing (DON) revealed she verbally notifies the resident or responsible party 5 days prior to the termination of Medicare benefits. She then completes the written notification for termination of Medicare benefits and obtains a signature from the resident or responsible party on the day benefits are ending. The DON stated the written notice for discontinuation of Medicare benefits should be submitted to the resident or responsible party two days prior to termination of Medicare coverage.</p> <p>3. Review of the Notice of Medicare Provider Non-Coverage, CMS form 10123, revealed a notice dated 2/17/11 to Resident #22, which stated current Medicare services would end on this date. A continued review of the notice revealed a signature indicating the responsible party for Resident #22 received the notice on 2/17/11.</p> <p>An interview on 3/24/11 at 11:09AM with the</p> | F 156 | | | |

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| F 156 | Continued From page 4 Director of Nursing (DON) revealed she verbally notifies the resident or responsible party 5 days prior to the termination of Medicare benefits. She then completes the written notification for termination of Medicare benefits and obtains a signature from the resident or responsible party on the day benefits are ending. The DON stated the written notice for discontinuation of Medicare benefits should be submitted to the resident or responsible party two days prior to termination of Medicare coverage. | F 156 | | | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to sit and face residents at eye level while feeding three (3) of fourteen (14) residents. (Residents #6, 10 and 16) The findings are: An observation on 03/22/11 at 8:30 AM was made of NA # 2 feeding residents in the dining room on the facility's secured unit. During the breakfast meal, NA #2 was standing to feed resident #10 and #16. NA #2 went between residents feeding one then the other. An observation on 03/24/11 at 9:05 was made of NA #3 feeding Resident #6 in the dining room of the facility's secured unit. NA #3 was standing | F 241 | Staff is seated and facing residents while feeding including the residents cited in this deficiency (residents #6, #10 and #16). All residents that reside on the secured unit and require feeding assistance have the potential of being affected by this practice although none were found to be affected. Education to nursing staff by DON and/or her designee on 3/30,31 and 4/2/11 regarding policy and procedure for appropriate position while feeding residents. | 4/22/11 | |

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| F 241 | Continued From page 5 over Resident #6 while feeding him. An interview was conducted on 03/24/11 at 9:35 AM with NA #2. NA #2 reported that she was trained to sit on a stool while feeding residents. She reported they are always in hurry. An interview was conducted on 03/24/11 at 9:40 AM with NA #3. NA #3 reported that we were trained to sit and face resident eye to eye while feeding them. She reported we are not to stand over them. She further reported she was trying to coach the resident to eat. An interview was conducted on 03/24/11 at 11:40 AM with the Director of Nursing who reported it is her expectation that staff should sit while feeding residents. | F 241 | QI audits of the feeding program in the secured unit dining room to be conducted by DON and/or her designee daily x 2 weeks, weekly x 1 month and monthly thereafter to ensure appropriate staff positioning during feeding residents. These findings to be reported to the QI Committee by the DON monthly x 12 months to determine need for further education and/or additional monitoring. | | |
| F 253 SS=B | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep floors clean in fourteen (14) of fourteen (14) resident bathrooms, to repair cracked resident toilets in two resident bathrooms, to repair scraped paint and plaster in two (2) of fourteen (14) resident rooms. The facility failed to clean a shower chair in one (1) of four (4) shower rooms. The findings are: | F 253 | Bathrooms are cleaned daily by the housekeeping department. Broken toilets have been replaced. Holes in the walls have been identified and fixed. Tiles have been replaced on those floors which show discoloration. All rooms and fixtures have the potential for defacement and broken fixtures. The facility staff have been informed of the procedure for notification to maintenance in regards to broken fixtures and defacement. The weekly Guardian Angel rounds also will identify potential issues. | 4/22/11 | |

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| F 253 | <p>Continued From page 6</p> <p>1. Observations on 03/22/11 at 8:30 AM were made during initial tour. Observation was made of a large puddle with a strong odor of urine in room 102's bathroom floor. All fourteen (14) bathroom floors on the 100 hall were stained with brown discolored floor wax as well as having dark brown caulk around toilet bases. The commodes in the joined bathrooms of rooms 107/109 and 111/113 had large cracks in the bases. There was a hole in the plaster in room 112. The hole was approximately four inches by two inches. There was paint and plaster scraped off the corner of a wall extending into room 109, the metal corner was exposed.</p> <p>An interview was done on 03/22/11 at 3:00 PM with the Maintenance Director. He reported that the facility's system was that if someone notices something that needed to be repaired he would be notified by a work order in his box. He further stated that he checks this box several times per day. When the broken toilets and the holes in the wall were pointed out to the Maintenance Director he reported he was unaware of these issues. He further reported that the facility was in the process of waxing floors, repairing floors and replacing the caulk around the toilets. He also reported that he was replacing the floor in room 102's bathroom because of the odor, as urine had seeped under the tile.</p> <p>2. An observation on 03/23/11 at 3:05 PM was made in the shower room on the 100 hall. Two raised areas one of about a nickel size and the other about a quarter size of brown matter were noted on the base of a shower chair. The shower room and stall were dry and had not been used on first shift.</p> | F 253 | The facility will be monitored by the maintenance director daily x 2 weeks, weekly x 4 weeks, and monthly. This will be brought before the QI/QA committee monthly x 12 months. | |

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| F 253 | Continued From page 7 An interview was conducted on 03/23/11 at 3:45 PM with the Housekeeping Manager. He reported that there is a room that is locked in the central hall where cleaner is dispensed and that a spray bottle is to be filled and locked in the shower room cabinet for the cleaning of showers and shower chairs. An interview was conducted on 03/23/11 at 3:55 PM with the Director of Nursing (DON). She reports that it is her expectation that shower chairs are to be cleaned between residents using the specified disinfectant cleaner. She further reported this cleaner is to be locked in the bathroom cabinet or if not staff should have access to the cleaner. The DON did not have an infection control policy specific to the cleaning of shower chairs. | F 253 | | |
| F 281 SS=E | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow physician's orders to provide the correct amount of nutritional supplement for three (3) of five (5) residents observed receiving nutritional supplements. (Residents #15, #5, and #12). The findings are: 1. Resident #15 was admitted to the facility 02/14/10 with diagnoses including Alzheimer's disease and coronary artery disease. An annual | F 281 | Residents #5, #12, and #15 are now receiving the appropriate amount of nutritional supplement per physician's order. All residents receiving nutritional supplement have the potential to be affected by this practice although none were found to be affected. Education to licensed nursing staff and medication aides/techs by the DON and/or her designee on 3/30, 31 and 4/2/11 on the policy and procedure of measuring and administering nutritional supplement. Med Pass observations on one nurse by the ADON to be completed daily x 2 weeks, weekly x 1 month then randomly thereafter. | 4/22/11 |

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| F 281 | <p>Continued From page 8</p> <p>Minimum Data Set dated 02/07/11 indicated severe impairment of cognition and dependence on staff assistance for all care. A Care Area Assessment dated 02/11/11 described Resident #15 with weight loss due to cognition. A care plan dated 03/11 identified Resident #15 with weight loss. The care plan goal was to stabilize weight loss with interventions including provide supplements as ordered with medication passes three times a day.</p> <p>A review of the Registered Dietician's (RD) note dated 01/18/11 revealed Resident #15 lost 5.2 pounds from 01/10/11 through 01/17/11. Continued review of the RD note revealed the resident was presently on two (2) oz. of a nutritional supplement tid (three times a day). The RD recommended the supplement to be increased to four (4) oz tid.</p> <p>A review of Resident #15's medical record revealed a physician's order dated 01/18/11 for four (4) oz. of a nutritional supplement (Med Pass) by mouth tid due to weight loss.</p> <p>On 03/24/11 at 8:45 a.m. Licensed Nurse (LN) #3 was observed as she administered a cup of nutritional supplement to Resident #15. The cup was observed half full. When she returned to the medication cart, LN #3 was observed measuring out four (4) oz of water in the same size cup used to administer the nutritional supplement. The water came to the top of the cup. LN #3 acknowledged she had administered two (2) oz of nutritional supplement to Resident #15.</p> <p>An interview with the Registered Dietician (RD) on 03/24/11 at 8:55 a.m. revealed nutritional supplements were calculated to provide the best</p> | F 281 | <p>QI audits to be conducted by the DON and/or her designee on the measuring of Med Pass nutritional supplement daily x 2 weeks, weekly x 1 month and monthly thereafter. Findings of these audits to be presented to the QI Committee monthly x 12 months to determine need for further education and/or additional monitoring.</p> | |

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| F 281 | <p>Continued From page 9</p> <p>nutrition possible for the residents. The RD added she expected nutritional supplements were administered as ordered.</p> <p>An interview with the Director of Nurses (DON) on 03/24/11 at 3:30 p.m. revealed the facility used a standard four (4) oz cup on the medication carts. She added the purpose of consistently utilizing the same cup on all medication carts was to provide accurate measurements of liquids.</p> <p>2. Lexi-comp's Drug Reference Hand Books 8th Edition dated 2007 states one (1) fluid ounce (oz) equals thirty (30) cubic centimeters (cc)</p> <p>Resident # 5 was readmitted to the facility 01/31/11 with diagnoses including congestive heart failure and anemia. A Minimum Data Set (MDS) dated 02/07/11 indicated Resident #5 was cognitively intact and required limited staff assistance for all care. The MDS assessment revealed the resident required staff encouragement when eating meals.</p> <p>An review of the Dietary Manager's (DM) note dated 02/15/11 revealed Resident # 5 experienced a 2.3 pound weight loss from 02/07/11 through 02/14/11. Continued review revealed the DM a recommended two (2) oz of a nutritional supplement added with medication administrations.</p> <p>A review of Resident #5's medical record revealed a physician's order dated 02/15/11 for two (2) oz of a nutritional supplement (Med Pass) with medications tid (three times a day) due to weight loss.</p> <p>An observation on 03/23/11 at 11:51 a.m.</p> | F 281 | | | |

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| F 281 | <p>Continued From page 10</p> <p>revealed Licensed Nurse (LN) # 2 prepared Resident #5's nutritional supplement by pouring approximately one (1) oz. into a cup. LN #2 was observed administering the supplement as prepared to Resident #5.</p> <p>In an interview on 03/23/11 at 11:56 a.m. LN #2 stated thirty (30) cc was two (2) oz.</p> <p>An interview with the Registered Dietician (RD) on 03/24/11 at 8:55 a.m. revealed nutritional supplements were calculated to provide the best nutrition possible for the residents. She added expected nutritional supplements to be administered as ordered.</p> <p>An interview with the Director of Nurses (DON) on 03/24/11 at 3:30 p.m. revealed the facility used a standard four (4) oz cup on the medication carts. She added the purpose of consistently utilizing the same cup on all medication carts was to provide accurate measurements of liquids.</p> <p>3. Resident #12 was admitted to the facility on 03/08/11 with diagnoses including Anxiety disorder, Coronary Artery Disease and Chronic Obstructive Pulmonary Disease. Admission Minimum Data Set (MDS) dated 03/18/11 revealed the resident was cognitively intact and independent with daily decision making. Review of a Nursing Care Plan dated 03/14/11 for Nutrition/Hydration Management included a goal for improvement in nutrition status. Interventions included liberalized diet and provision of snacks.</p> <p>A review of Resident #12's medical record revealed a physician's order dated 03/10/11 for four (4) ounces of a nutritional supplement by mouth three times a day (TID).</p> | F 281 | | | |

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| F 281 | <p>Continued From page 11</p> <p>A review of Resident #12's Medication Administration Record (MAR) for March 2011 revealed the order Med Pass (nutritional supplement used by the facility) four (4) ounces three times a day.</p> <p>On 03/22/11 at 4:15 p.m. Licensed Nurse (LN) #2 was observed as he administered a liquid nutritional supplement to Resident #12 in a four ounce cup. LN #2 was observed to pour approximately one ounce of a nutritional supplement into the cup and then poured approximately three ounces of water into the cup to fill it full of liquid. LN #2 stated he had administered 4 ounces nutritional supplement to Resident #12.</p> <p>On 03/24/11 at 8:00 a.m. Medication Aide #1 was observed as she administered a liquid nutritional supplement to Resident #12 in a four ounce cup. The cup was observed to contain approximately two ounces of a nutritional supplement and the Medication Aide added approximately two ounces of water to the cup to fill it full of liquid. Interview with Medication Aide #1 acknowledged that she had only administered two ounces of nutritional supplement to Resident #12. Resident #12 asked for an additional cup of nutritional supplement to take with medications. Medication Aid #1 filled a cup half full of nutritional supplement and added water to the top. Medication Aid #1 stated she would only give Resident #12 two ounces of the nutritional supplement and would give the resident more only if asked.</p> <p>An interview with the Registered Dietician (RD) on 03/24/11 at 8:55 a.m. revealed nutritional supplements were calculated to provide the best</p> | F 281 | | |
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| F 281 | Continued From page 12 nutrition possible for the residents. The RD added she expected nutritional supplements were administered as ordered and should not be diluted to make the full 4 ounce dose. An interview with the Director of Nursing (DON) on 03/24/11 at 3:30 p.m. revealed the facility used a standard four (4) ounce cup on the medication carts. She added the purpose of consistently utilizing the same cup on all medication carts was to provide accurate measurements of liquids. The DON further revealed the nutritional supplement should not be diluted and should have been administered as ordered by the physician. | F 281 | | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to ensure an oxygen cylinder was stored securely for one (1) of five (5) sampled residents on oxygen. (Resident #6) The findings are: Resident #6 was originally admitted to the facility 2/6/09 and readmitted 2/25/11 with physician orders which included , "O2 via nasal cannula | F 323 | F323 – Accidents/Supervision Oxygen cylinders are now stored securely for Resident #6. All residents receiving oxygen and residing on the secured unit have the potential to be affected by this practice although none were found to be affected. Education to nursing staff by the DON and/or her designee on 3/30, 31 and 4/2/11 on the policy and procedure for oxygen storage. Weekly Guardian Angel rounds to include observations of proper oxygen cylinder storage and documented on Guardian Angel round sheets. Any oxygen cylinders found to be stored incorrectly will be corrected immediately. | 4/22/11 | |

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| F 323 | <p>Continued From page 13 during daytime hours to maintain oxygen saturation greater than 90%." Resident #6 resided in a shared room on the locked dementia unit of the facility.</p> <p>On 3/23/11 at 8:05 AM an oxygen cylinder and oxygen concentrator were observed in the room of Resident #6. The oxygen cylinder was in a sleeved jacket (designed to hold the tank and attach to the back of a wheelchair). The cylinder was not secured and was propped against a dresser. The dresser was against a wall and in front of the dresser was a pathway which was bordered by the foot of the resident's bed. An overbed table and the resident's wheelchair were in the pathway, within a foot of the oxygen cylinder. The resident was observed in bed.</p> <p>At 8:15AM a nursing assistant entered the resident's room and assisted him to get dressed and into the wheelchair. At 8:25AM the nursing assistant wheeled the resident out of the room, passing by the area where the oxygen cylinder was propped against the dresser. At 8:56AM an ambulatory resident on the dementia unit wandered into Resident #6's room, looked around, and exited the room. At 9:15 AM this same resident again entered the room, pulled back the privacy curtain (between Bed A and Bed B) and exited the room. At 9:25AM the concern of the storage of the unsecured oxygen cylinder was shared with the Director of Nursing (DON). The DON removed the oxygen cylinder from the dresser and noted it contained 1300 pounds of pressure. The DON stated the oxygen cylinder should have been either on the back of the resident's wheelchair or secured in a portable rolling oxygen holder. The DON stated she would inquire of staff that had worked with Resident #6</p> | F 323 | <p>QI audits to be conducted by the DON and/or her designee on proper oxygen cylinder storage daily x 2 weeks, weekly x 1 month and monthly thereafter. Findings of these audits to be presented to the QI Committee monthly x 12 months to determine need for further education and/or additional monitoring</p> | | |

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| F 323 | Continued From page 14 to determine who stored the cylinder against the dresser. On 3/24/11 at 2:45 PM the DON stated she spoke with staff that worked with Resident #6 on 3/22/11 and 3/23/11 and was not able to determine who stored the oxygen cylinder against the resident's dresser. The DON stated it was unusual to have a resident on the dementia unit requiring an oxygen cylinder and, since bringing the concern to her attention, an oxygen holder was placed in a closet, behind the locked nursing station to house oxygen cylinders. | F 323 | | |
| F 333 SS=D | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to discontinue a diuretic medication as ordered for one (1) of seventeen (17) sampled residents during medication review (Resident #2) and to ensure a timed released medication was administered without crushing for one (1) of seventeen (17) residents observed for medication administration (Resident #2). The findings are: Resident #2 was admitted to the facility on 06/28/10 with diagnoses including Diabetes Mellitus, Subdural Hematoma, and Congestive Heart Failure. The latest Minimum Data Set (MDS) dated 12/30/10 revealed the resident's cognitive skills for daily decision making was severely impaired. The MDS also revealed the | F 333 | Resident #2 is now receiving Lasix per physician order. All residents receiving Lasix have the potential of being affected by this practice although none were found to be affected. | 4/22/11 |

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| F 333 | <p>Continued From page 15</p> <p>resident required extensive assistance with activities of daily living.</p> <p>A review of Resident #2's medical record revealed a physician order dated 01/04/11 read 'Discontinue Lasix'. A review of the Medication Administration Record (MAR) for January 2011 indicated the discontinuation of Lasix on 01/04/11. A review of the February 2011 MAR revealed Lasix 20 mg tablet by mouth every other day and was given daily for a total of twenty (20) doses then every other day for three (3) doses. A review of the March 2011 MAR revealed Lasix 20 mg tablet by mouth every other day and was given every other day for a total of eleven (11) doses.</p> <p>On 03/23/11 at 9:15 a.m. Medication Aide #2 was interviewed. She acknowledged that she did not realize the Lasix was discontinued 01/04/11 since the order was on the 03/11 MAR. She further indicated she depends on the current MAR to pass medications and she would know if a medication was discontinued by a yellow hi-light over the medication and date discontinued.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 03/23/11 at 9:30 a.m. revealed new physician medication orders are flagged in the medical record, faxed to the pharmacy and handwritten on the current MAR until a new computer generated MAR is sent to the facility. The interview further revealed a Licensed Nurse (LN) completes a MAR to MAR audit at the end of each month and was uncertain how the discontinued medication remained on the MAR.</p> <p>An interview on 03/24/11 at 2:30 p.m. with the facility's consultant pharmacist revealed faxed</p> | F 333 | <p>Resident #15 is now receiving Lopressor as ordered and is being crushed.</p> <p>All residents receiving Toprol have the potential of being affected by this practice although none were found to be affected.</p> <p>4/22/11</p> |

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| F 333 | <p>Continued From page 16</p> <p>physician orders are received in the dispensing office, compared with past MARs, entered into the computer and a new MAR is printed and sent to the facility. The consultant pharmacist further revealed he reviews the current physician order sheet and compares with the previous MARs located in the medical record and does not review the current MAR. The pharmacist indicated he was aware of the error and is working on his process to catch errors.</p> <p>2. Facility undated document Medications Not To Be Crushed listed Toprol (Metoprolol) XL/SR due to time released formulation.</p> <p>Resident #15 was admitted to the facility 02/14/10 with diagnoses including atrial fibrillation, coronary artery disease, and Alzheimer's disease. A Minimum Data Set dated 02/07/11 indicated severe impairment of cognition and dependence on staff assistance for all care.</p> <p>A review of the Medication Administration Record dated 03/01/11 through 03/30/11 revealed Metoprolol SR 25 milligrams (mg) one tablet by mouth every day.</p> <p>On 03/22/11 at 7:50 a.m. Licensed Nurse (LN) #1 was observed preparing medication for administration to Resident #15. Continued observation revealed LN #1 added Metoprolol XL 25 mg to a plastic pouch containing other medications. LN #1 was observed placing the pouch containing the medications into a device utilized for crushing. Before the medications were crushed, she was asked by the surveyor if the Metoprolol was in the container and if it was a time released tablet. LN #1 replied the medication was in the pouch and verified the</p> | F 333 | <p>Education to licensed nursing staff and medication aides/techs by the DON/ADON on the policy and procedure of medication administration on 3/13/11 and 3/14/11. Education to licensed nursing staff and medication aides/techs by the DON/ADON on the policy and procedure of transcribing medication orders appropriately. Audit of current resident physician orders will be completed by 4/17/11 to identify any possible medication and/or transcription errors. Physician orders will be compared to MARS/TARS with the monthly changeover process. List of medications that are not to be crushed have been placed in the front of each MAR.</p> <p>QI audits to be conducted by DON/ADON on proper medication administration daily x 2 weeks, weekly x 1 month and monthly thereafter. QI audits to be conducted by the DON/ADON on proper transcription of medication orders daily x 2 weeks, weekly x 1 month then monthly thereafter. Findings of these audits to be presented to the RM/QI committee monthly by the DON x 12 months to determine need for further education and/or additional monitoring.</p> | |
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| F 333 | Continued From page 17 office, compared with past MARs, entered into the computer and a new MAR is printed and sent to the facility. The consultant pharmacist further revealed he reviews the current physician order sheet and compares with the previous MARs located in the medical record and does not review the current MAR. The pharmacist indicated he was aware of the error and is working on his process to catch errors. | F 333 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which | F 441 | The staff involved in the violations of the Infection Control Policies have been counseled and retrained in the correct procedures. All residents are at risk for development of infection and disease through the violations of the Infection Control Policies though none were found to be affected. All licensed staff have been educated in regards to glove use, hand washing, and handling of linen. This occurred on 3/29/2011, 3/31/2011, and 04/02/2011. QI audits of the glove, hand washing and linen procedures will be performed daily x 2 weeks, weekly x 4, and monthly. These audits will be taken to the QI committee for discussion monthly x 12 months. | 4/22/11 |

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| F 441 | <p>Continued From page 18</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, facility protocol, and staff interviews, the facility failed to wash hands or apply gloves when performing invasive procedures with possible body fluid contact for three (3) of four (4) observed residents. (Residents #21, #23, and #2). The facility also failed to handle linens in a manner to prevent the spread of infection with one (1) of three (3) observed staff members.</p> <p>The findings are:</p> <p>1. A review of facility protocol for Blood Glucose Testing, revised date of 02/10, contained before beginning the procedure, wash hands and apply gloves. The protocol continued after the needle is removed from the lancet holder and discarded, remove gloves and wash hands.</p> <p>Resident #2 was admitted to the facility on 06/28/10 with diagnoses including Diabetes Mellitus.</p> <p>On 03/22/11 at 4:30 p.m. Licensed Nurse (LN) #2 was observed obtaining a finger stick blood sugar from Resident #2. After piercing the resident's thumb and producing a drop of blood for the test</p> | F 441 | | | |

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| F 441 | <p>Continued From page 19</p> <p>strip, LN #2 was observed placing an alcohol pad over the stick site to stop the bleeding. LN #2 was observed not wearing gloves during the procedure and not washing his hands before or following the procedure.</p> <p>An interview with LN #2 on 03/22/11 at 4:40 p.m. revealed it is his practice not to wear gloves during finger sticks.</p> <p>An interview with the Assistant Director of Nurses (ADON) on 03/23/11 at 1:20 p.m. revealed she expected staff to wear gloves when performing procedures that could expose them to body fluids. The ADON continued she expected staff to wash their hands after and between resident contact.</p> <p>2. A review of facility protocol for Blood Glucose Testing, revised date 2/10, contained before beginning the procedure, wash hands and apply gloves. The protocol continued after the needle is removed from the lancet holder and discarded, remove gloves and wash hands.</p> <p>A review of facility protocol related to handwashing, revised date 6/06, revealed handwashing is mandated between resident contact in an effort to prevent the spread of infection.</p> <p>Resident # 21 was readmitted to the facility 01/29/11 with diagnoses including diabetes mellitus.</p> <p>On 03/23/11 at 11:25 a.m. Licensed Nurse (LN) # 2 was observed obtaining a finger stick blood sugar from Resident #21. After piercing the resident's finger and producing a blood drop, LN #2 was observed holding an alcohol pad over the</p> | F 441 | | | |

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| F 441 | <p>Continued From page 20</p> <p>stick to stop the bleeding. LN #2 was observed not wearing gloves during the procedure and not washing his hands before or following the procedure. Continued observation revealed LN #2 prepared and administered Insulin as ordered per injection to Resident #21. LN #2 was observed not wearing gloves during the injection and did not wash his hands before or after the injection. After removing the needle, LN #2 held an alcohol pad over the injection site to assure no bleeding occurred. Further observation revealed LN #2 administered medications by mouth to two (2) other residents before washing his hands.</p> <p>An interview with LN #2 on 03/23/11 at 12:00 p.m. revealed it is his common practice not to wear gloves when obtaining finger stick blood sugars or administering injections. He stated he could not "feel" through the gloves. LN #2 did acknowledge finger sticks and injections created a possible exposure to blood. LN #2 continued it was his usual practice to wash his hands after resident contact. He added he did not do that when observed today.</p> <p>An interview with the Assistant Director of Nurses (ADON) on 03/23/11 at 1:20 p.m. revealed she expected staff to wear gloves when performing procedures that could expose them to body fluids. The ADON continued she expected staff to wash their hands after and between resident contact.</p> <p>3. A review of facility protocol for Blood Glucose Testing, revised date 2/10, contained before beginning the procedure, wash hands and apply gloves. The protocol continued after the needle is removed from the lancet holder and discarded, remove gloves and wash hands.</p> | F 441 | | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345447 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 03/24/2011 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER EMERALD RIDGE REHAB AND CARE C | | | STREET ADDRESS, CITY, STATE, ZIP CODE 25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 441 | <p>Continued From page 21</p> <p>A review of facility protocol related to handwashing, revised date 6/06, revealed "handwashing is mandated between resident contact in an effort to prevent the spread of infection".</p> <p>Resident #23 was admitted to the facility 06/23/11 with diagnoses including diabetes mellitus.</p> <p>On 3/23/11 at 11:45 a.m. Licensed Nurse (LN) # 2 was observed obtaining a finger stick blood sugar from Resident #23. After piercing the resident's finger and producing a blood drop, LN #2 was observed holding an alcohol pad over the stick to stop the bleeding. LN #2 was observed not wearing gloves during the procedure and not washing his hands before or following the procedure. Continued observation revealed LN #2 prepared and administered Insulin as ordered per injection to Resident #23. LN #2 was observed not wearing gloves during the injection and did not wash his hands before or after the injection. After removing the needle, LN #2 held an alcohol pad over the injection site to assure no bleeding occurred.</p> <p>An interview with LN #2 on 03/23/11 at 12:00 p.m. revealed it is his common practice not to wear gloves when obtaining finger stick blood sugars or administering injections. He stated he could not "feel" through the gloves. LN #2 did acknowledge finger sticks and injections created a possible exposure to blood. LN #2 continued it was his usual practice to wash his hands after resident contact. He added he did not do that when observed today.</p> <p>An interview with the Assistant Director of Nurses</p> | F 441 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345447 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 03/24/2011 |
| NAME OF PROVIDER OR SUPPLIER EMERALD RIDGE REHAB AND CARE C | | | STREET ADDRESS, CITY, STATE, ZIP CODE 25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 441 | <p>Continued From page 22</p> <p>(ADON) on 03/23/11 at 1:20 p.m. revealed she expected staff to wear gloves when performing procedures that could expose them to body fluids. The ADON continued she expected staff to wash their hands after and between resident contact.</p> <p>4. The facility's infection control policy dated 11/09 reads in part: the facility strives to reduce the risk of infection to the resident. Linens will be handled as little as possible and with a minimum of agitation to prevent gross microbial contamination of the air.</p> <p>On 03/23/11 at 11:45 AM, NA #1 was observed walking down the 100 hall holding clean linen against her uniform scrub top. NA #1 proceeded to go into a resident's room and make the resident's bed with the linens. While putting the top sheet and the bedspread on the bed fanned them into the air several times prior to tucking them into the bottom of the bed.</p> <p>On 03/23/11 at 3:15 PM NA #1 was interviewed. NA #1 reported she should not have fanned the linen and she should not have held the linen next to her scrubs as that can cause cross contamination. She reported she was trained differently.</p> <p>On 03/24/11 at 3:00 PM the ADON was interviewed. She reported that linens were to be held away from scrubs and linens were not to be fanned while making a bed. She further stated it was bad practice and should have known this from her training prior to employment.</p> | F 441 | | | |