DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/15/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. C	938-039
	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTI A. BUILDIN		NSTRUCTION	(X3) DATE SUI COMPLET	
		345447	8. WNG _	•:		. с	
	DOWNER OF CURRULE	345447	o. WING _	CIDE	ET ADDRESS, CITY, STATE, ZIP CODE	07/29/	/2016
NAME OF P	ROVIDER OR SUPPLIER				YNOLDS MOUNTAIN BOULEVARD	(E.	
EMERAL	RIDGE REHAB AND CA	ARE CENTER			EVILLE, NG 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	DBE . C	(XS) COMPLETION DATE
		83.10(b)(1) NOTICE OF	, F1	56 1	, and tradit injured		
SS=C	RIGHTS, RULES, SE	RVICES, CHARGES			to this citation. Resident #2) was	
	The facility must infor	m the resident both orally			made aware of the central in	ıtake	
		guage that the resident			number and where to find		
		her rights and all rules and			information on 8/15/2016 by	the :	
		resident conduct and the stay in the facility. The			Executive Director.	1	
		ride the resident with the		2)	On 07/27/2016 the Executiv	e	
	notice (if any) of the S	State developed under			Director reposted the State of		
	On toward contraction of the party of the contraction of the	t. Such notification must be			Carolina Complaint Intake Ur		
		admission and during the ipt of such information, and			number.	in phone	
		, must be acknowledged in		3)		i	
	writing.	-		٠,	serviced by the Regional Dire		
		W . T. WINGTON . WOODS					
		m each resident who is enefits, in writing, at the time		1	Clinical Services on 8/08/16 o		
		ursing facility or, when the		1	posting of the state of North		
		gible for Medicaid of the		i	Complaint Intake Unit phone		
		at are included in nursing		!	The Executive Director will pe		
		the State plan and for ay not be charged; those			Quality Improvement Monito		
		ces that the facility offers		9	the availability of the central		
		dent may be charged, and			number one time a week for		
		s for those services; and			months and then quarterly th	ereafter	
		when changes are made to		8	for one year.		
	(i)(A) and (B) of this s	s specified in paragraphs (5)		4)	The Executive Director introd	uced the	
	(1)(1) 0110 (2) 01 1110 0				plan of correction to the Qual	ity	
		m each resident before, or			Assurance Performance Impro		
		on, and periodically during			Committee on 8/22/2016. The		
	facility and of charges	services available in the for those services,			results of the audits will be re		
		for services not covered			to the Quality Assurance Perfe	•	
	under Medicare or by	the facility's per diem rate.			Improvement Committee Med		
	The feetile	ah a weittan donesiation of		ĸ	monthly then quarterly for a y		
	legal rights which incl	sh a written description of udes:	8	ϵ		cal,	
i	•	anner of protecting personal		•		į	

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 in deficience are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Cosciete

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Facility ID 923161

TITLE

If continuation sheet Page 1 of 67

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILDI	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
		345447	B. WING	3		. C 07/29/2016
EMERALI	ROVIDER OR SUPPLIER D RIDGE REHAB AND CA	RE CENTER	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804 PROVIDER'S PLAN OF CORREC	TION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	EIX (EACH CORRECTIVE ACTION SHO	JLO BE	
	for establishing eligibithe right to request an 1924(c) which determ non-exempt resources institutionalization and spouse an equitable scannot be considered toward the cost of the medical care in his or down to Medicaid eliging. A posting of names, an umbers of all pertinengroups such as the Stagency, the State licenombudsman program, advocacy network, and unit; and a statement to complaint with the Stagency concerning resimisappropriation of refacility, and non-compidirectives requirement. The facility must informate, specialty, and volves physician responsible. The facility must promivitten information, an applicants for admission information about how Medicare and Medicaid	quirements and procedures lity for Medicaid, including assessment under section ines the extent of a couple's at the time of attributes to the community hare of resources which available for payment institutionalized spouse's her process of spending bility levels. Indicate the time of a couple's sher process of spending bility levels. Indicate the process of spending bility levels. In the protection and at the Medicaid fraud control hat the resident may file a te survey and certification is the survey and certification is dent abuse, neglect, and is ident abuse, neglect, and is ident property in the lance with the advance s. In each resident of the vay of contacting the for his or her care. In ently display in the facility deprovide to residents and on oral and written to apply for and use	F	The Quality Assurance Perform Improvement Committee mem consist of but not limited to the Executive Director, Director of O Services, Unit Manager, Staff Development, Activities, Medica Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Se Coordinator.	bers Clinic	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONS	TRUCTION	(X3) DATE SURVEY COMPLETED
		and a second			¥	, с
		345447	B. WING			07/29/2016
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
EMERALO	RIDGE REHAB AND CA	RE CENTER			NOLDS MOUNTAIN BOULEVARD	
				ASHEV	/ILLE, NC 28804	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRISE DEFICIENCY)	
F 156	Continued From page	2	F	156		2
		is not met as evidenced		1		
	by: Based on observation	ns, and resident and family	1	į.		20
		ailed to inform residents of				il V
		plaint with the state agency	ï	b		
		t information for filing a		ı		¥
	(Resident #20).	te Complaint Intake Unit		ē		i
	Tr. C. C. C. Jan.		\$ E	į.		
	The findings included:			i		Ť
	1. Resident #20 was a	dmitted to the facility on	f) 5			1
,		es which included anemia,	*1	į		į
:		pressure, and depression.	į	Ŧ		
1	Review of the Quarter	150c	į.	İ		
:	was cognitively intact.	revealed Resident #20				•
1	was cognitively intuot.					10 10 10
		lucted on 07/28/16 at 10:11				
		. Resident #20 reported she	!			
	was the President of the	ne Resident Council. Oncerns and issues were		340 M		
	discussed in the month			i): 1
1		ne information to formally	i			
į	한다. 아이지 않는 회사에서 회사를 가면 어떻게 되었다며 그렇다	e state was not discussed.		9.		11
		tated was not aware of the	i.	ä		
1	intake unit. Resident	rtification agency complaint \$20 explained she was not		i.		
İ		osted in the facility and had		Ť		
	not seen the name or	number posted of the	i	1		
	complaint intake unit. I			•		ř
İ	5.	sure if other residents knew	9			
	where to obtain that in	ormation. or of the facility on 07/25/16	i			<u>}</u>
1		ons were made of contact		1		
	information posted rela		**			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		STRUCTION	(X3) DATE SURVEY COMPLETED	
						c	
		345447	B. WING			07/29/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 0772372010	
				25 REY	NOLDS MOUNTAIN BOULEVARD		
EMERALI	RIDGE REHAB AND CA	RE CENTER		ASHE	VILLE, NC 28804		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	- WE	
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B		
TAG	REGULATORTORE	SCIDENTIF TING INFORMATION)	TAG	100	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE	
			-,	•			
F 156	Continued From page	3	. Е	156		(20)	
		ormation was the following:		100			
		ig of resident rights was	£	í			
		rvices is responsible for the	v.				
		t rights." Included with this		1			
	statement were two pl					1	
	the second second free contract to the second secon	not contact information for	1				
		nit and there was nothing to	** **				
		a complaint with the State	1				
	agency.		10			1	
	-A posting for "Resider	nt grievance/complaint		6			
	procedures" listed step	os to file a					
	grievance/complaint a	nd listed steps the facility					
	would take to resolve t	he concern. Included with	İ				
Va.	the posting was the sta	atement, "Should you	İ				
	disagree with the findir	ng, recommendations or	1	14			
		meet with the executive		1			
		a complaint with any of	f	1			
	the agencies listed on		1	1		ř.	
	board." The residents'			i		ĺ	
		the complaint intake unit or		*			
i		the right to file a complaint		18 19		*	
1	with the State agency.		1				
4		or how to file a complaint	i				
1	with the corporate offic	e.		1			
	On 07/27/16 of 9:47 M	M the facility administrator					
		ible for information posted	1				
	in the facility. The adm			30			
		information was posted	3.				
		ted and staff may have	v r	i		i	
	forgotten to place all in					!	
	bulletin boards.		1			İ	
į	400 mar 17 18 18 18 18 18 18 18 18 18 18 18 18 18			*			
:	On 07/27/16 at 10:13 A	M the maintenance					
3	director stated the area	where the bulletin board					
	containing contact infor	mation was posted had				:	
	been painted a couple		E.			ļ	
1						î	
l.	On 07/27/16 at 1:00 PM	If the administrator stated	1	1			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED	
		345447	B. WNG		¥1	. (29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	077.	29/2010
	2 724 2			S REY	NOLDS MOUNTAIN BOULEVARD		
EMERALD	RIDGE REHAB AND CA	RE CENTER		ASHE	/ILLE, NC 28804		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 156	complaint with the Sta	tinformation for posting a ite agency in a storage	F 156			100	
		ong with other contact signated bulletin board.	3 4. 7	t.			×
		ed the information had	3(0))	i			
		in the storage closet after	9				
E 167	the hallway was painte	o Survey results -	F 167				
	READILY ACCESSIBL		1 107	1)	No residents were injured relat this citation.	ed to	
	the most recent survey Federal or State survey correction in effect with The facility must make examination and must	at to examine the results of y of the facility conducted by eyors and any plan of the respect to the facility. The the results available for post in a place readily as and must post a notice of		2)	The Executive Director labeled survey binder and labeled its lo in large print on 7/27/2016. The Executive Director was in serviced by the Regional Director Clinical Services on 8/08/16 on labeling of survey binder and the labeling of its location. The Exerpirector will perform Quality	or of the	
	by: Based on observation facility failed to identify	of the results of the most		4)	Improvement Monitoring of the survey binder's availability and labeling one time a week for 3 months and then quarterly thereafter for one year. The Executive Director introduce		
	10:10 AM observations information posted with	f the facility on 07/25/16 at s were made of contact nin the facility. There was	2	7/	plan of correction to the Quality Assurance Performance Improve Committee on 8/22/2016. The results of this audit will be repor	ement	
i	of the most recent surv Located on the front er	g the location of the results yey by the State agency. Intrance hallway of the ed teal binder inside an			to the Quality Assurance Perforn Improvement Committee memb for monthly for three months the	nance	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		ISTRUCTION		E SURVEY MPLETED
		345447	B. WING _		P	. 0	C 7/29/2016
1)	ROVIDER OR SUPPLIER O RIDGE REHAB AND CA	RE CENTER		25 RE	T ADDRESS, CITY, STATE, ZIP CODE YNOLDS MOUNTAIN BOULEVARD VILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 167	nothing to identify whithe teal binder. Revieinformation inside the results of the most recapency. On 07/27/16 at 8:47 A stated he was responsin the facility. The adientrance hallway whe had been recently pai stated if interested paid for survey results they to the teal binder. The wall mounted docume removed when the hat On 07/27/16 at 10:13 director stated the entipainted a couple monton of the was aware interest to ask for the location administrator stated the	ocument holder. There was at documents were inside the of the content of teal binder noted the cent survey by the State. M the facility administrator sible for information posted ministrator stated the re information was posted inted. The administrator rites asked for the location would have been directed a administrator stated the intholder had been fliway was painted. AM the maintenance rance hallway had been this prior. M the administrator stated ed parties should not have of the survey results. The ne document holder had indicate the binder contained	F 1	57	quarterly thereafter for a year. T Quality Assurance Performance Improvement Committee member consist of but not limited to the Executive Director, Director of Cl Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	ers inical	8/25/16
F 225 SS=D	agency. 483.13(c)(1)(ii)-(iii), (c INVESTIGATE/REPO ALLEGATIONS/INDIV The facility must not e been found guilty of al mistreating residents t had a finding entered)(2) - (4) RT IDUALS mploy individuals who have	F 22	1)	Resident #18 was not injured related this citation. The facility subma 5 day working report on 9/3/20 Resident #158 no longer resides the facility. The facility submitted day working report on 8/31/2019 Resident #72 was not injured related to the facility was not injured related to the facility was not injured related to the facility was not injured related to the facility was not injured related to the facility was not injured related to the facility was not injured related to the facility was not injured related to the facility was not injured related to the facility submitted to t	nitted 015. at d a 5	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULT A BUILDI		STRUCTION	(X3) DATE SURVEY COMPLETED	
		345447	B. WING				0
	DOLLDED OR ALIDOLIED	343447	1 0. 7mmo	ernee	T 1000000 0174 07175 710 0005	07/	29/2016
NAME OF P	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE YNOLDS MOUNTAIN BOULEVARD		
EMERALI	RIDGE REHAB AND CA	RE CENTER		Complete Common	VILLE, NC 28804		
500 00	A WILLIAM AT	TELEPT OF DECIDIONALS		AOTIL	Angelia de Caración de Caració		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
				ě.			
F 225	Continued From page	6	F	225	to this citation. The facility sub	mitted	
	of residents or misappropriation of their property; and report any knowledge it has of actions by a			Ĭ	a 24 hour report on 4/15/2016.		
		edge it has of actions by a nemployee, which would		2)	Review of incidents to ensure	,	
		service as a nurse aide or		i	incidents have been reported as	S .	
		e State nurse aide registry			required by the Executive Direct		
	or licensing authorities	S.		9	8/18/2016-8/24/2016.		
	The facility must ensu	re that all alleged violations		3)	The Executive Director and Dire	ctor	
	involving mistreatmen	The state of the s		5.6	of Clinical Services were in servi		
	including injuries of ur			-	by the Regional Director of Clini		
		sident property are reported		1	Services on 8/8/2016 on the sta		
		ministrator of the facility and cordance with State law	ti.	i	North Carolina reporting	teoi	
		rocedures (including to the	Į.	1.87	requirements for allegations of	i	
	State survey and certi	fication agency).			abuse. The Executive Director w	!	
	The facility would be us	avidages that all alleged		12		VIII ;	
		evidence that all alleged hly investigated, and must		i i	perform Quality Improvement	į	
	prevent further potenti				Monitoring of any reportable ev	t	
	investigation is in prog		(15))	ii.	for timely submission to the stat		
		0.0	ì	95 95	time a week for three months a	(SOC)STATE	
	to the administrator or	stigations must be reported	(*) (*)		then quarterly thereafter for on	e	
		other officials in accordance			year.	1	
	with State law (including	ng to the State survey and		4)	The Executive Director Introduce	ed the	
		rithin 5 working days of the		10	plan of correction to the Quality	. !	
		eged violation is verified action must be taken.			Assurance Performance Improve	ement :	
	appropriate corrective	donor madred tanon.			Committee on 8/22/2016. The	i	
				8	results of this audit will be repor	ted	
	This DECUMENT	is not met as evidenced			to the Quality Assurance Perform	nance	
19	by:	is not met as evidenced	4	35	Improvement Committee memb		
		ew and staff interviews the	Į.		monthly for three months then	ž.	
		abuse/neglect allegation		i	quarterly thereafter for a year.	The	
	investigations to the S			i	Quality Assurance Performance		
		n (HCPI) for 2:5 residents port (Residents #18 and		1	Improvement Committee memb	ers	
		omit neglect allegation		1		(13	

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAI	(X3) DATE SURVEY COMPLETED	
		345447	B. WING			C 7/29/2016	
	(EACH DEFICIENCY	RE CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION SHOULD BE	(X5) COMPLETICN DATE	
The second distribution of the second distributi	An Annual Minimum Dindicated Resident #18 A review of the incider indicated that on 08/24 Coordinator witnessed Director being verbally The Admission's Coordinator between Director (HRD) and Rewith the Executive Dire HRD was pointing her holding Resident #18's Resident #18 to hush. Coordinator intervened stopped. The Admission the incident to the approbacies the ED was in abuse. A record review indicate for Resident #18 was in a corporate staff membor on 07/28/16 at 3:40 PM was conducted with a seconducted nitial Report for 1:5 72). Indmitted to the facility on Pata Set dated 06/21/16 B was cognitively intact. It of abuse dated 08/24/15 In 15 the Admission's It he Human Resource In abusive to Resident #18. In ator witnessed a "heated of the Human Resource esident #18 in the hallway ector (ED) present. The finger at Resident #18 and hand down and told The Admission's In and the HRD's yelling In's Coordinator reported opriate corporate staff volved in the allegation of ed the allegation of ed the allegation of ed the allegation of abuse investigated on 08/24/16 by er. If a telephone interview estaff member at the States' the HCPI had received a president #18 on ing Day Report for	F	consist of but not limited Executive Director, Direct Services, Unit Manager, S Development, Activities, I Director, Social Services, Maintenance Director, Director, Oil Manager and Minimum D Coordinator.	tor of Clinical Staff Medical etary	8/25/16		

					OHIO 110. 0000 0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		and to although the contra			, с
		345447	B. WING		07/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CALCOVI	RIDGE REHAB AND CA	DE CENTER		26 REYNOLDS MOUNTAIN BOULEVARD	
CINCRALI	AIDOC KETIAB AND CA	ARE CENTER		ASHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 225	Continued From page	8	F 225		
	On 07/28/16 at 4:25 F	PM an interview was		1	
	conducted with the Ex	recutive Director (ED) who			
	stated he was ultimate	[[[[[[[[[[[[[[[[[[[9		i
		I the 24 Hour Initial Report	24	7	ń
		y Report for Resident #18.		T.	18
		Vorking Day Report was			
		1 day late. The ED stated		1	İ
		ber submitted the 24 Hour	1	*	1
		5 Working Day Report			
	abuse.	involved in the allegation of	4		
į	aduse.				
	2 Resident # 156 was	admitted to the facility on		ii,	
	07/03/15.	admitted to the facility of		E	
1	01700710.		İ	₽j	
	An Admission Minimus	m Data Set dated 07/10/15	Į		
		56 was cognitively impaired.	į		
		, ,	4		1
	A review of the incider	nt of neglect dated 08/20/15		## ##	,
	indicated that on 08/20	0/15 Resident #156 was not	ž.		
	taken to the bathroom	on the night shift by Nurse	i.		1
	Aide #2.		I		
Ý		ted the allegation of neglect	î.		i i
		investigated on 08/20/16			
1	by the Executive Direct	ctor.			:
1	0- 07/00/40 -10:40 5	M a talanhana lataa law			
Î		M a telephone interview staff member at the States'	i		
*		the HCPI had received a	;		
	24 Hour Initial Report		i	1	
	08/21/15 and a 5 Work				!
	Resident #156 on 08/3		ļ		İ
İ	1,03,001, 7,100 01, 0070	. MACONITATION	1		
ļ	On 07/28/16 at 4:25 P	M an interview was	1	1	
i i		ecutive Director (ED) who			1
	stated he was ultimate		1		
		the 24 Hour Initial Report			1
		Report for Resident #156.	1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		NSTRUCTION	(X3) DATE SURVEY COMPLETED
	345447	B. WNG _			C 07/29/2016
NAME OF PROVIDER OR SUPPLIER EMERALD RIDGE REHAB AND CA	ARE CENTER		25 REY	ET ADDRESS, CITY, STATE, ZIP CODE YNOLDS MOUNTAIN BOULEVARD EVILLE, NC 28804	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	2	PROMDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 20E Octored From page	~	-			
F 225 Continued From page		F 2	25		
	Working Day Report was				
	I 1 day late. The ED stated		38		
he required a better to		QP.			
	king Day Report to the				
HCPI.			gi.		
	~ * * * * * * * * * * * * * * * * * * *		1		
£	admitted to the facility on		1		
03/19/15.					1
	where the commence constitute and the constitution of				ti
	Data Set dated 06/04/16	20	25		
	2 was cognitively impaired				XI
	continent of urine and	8	1		
occasionally incontine	int of bowel.				5)
A t of a 2.4 lattic			i		
	Report indicated Resident	4	ż		*
	of neglect. The date of the	ă	1		
	reported as occurring on				
	00 AM and 3:30 AM. A	4	1		1
	on revealed Resident #72		1		1
	om assistance on 04/12/16		*		9
at 2:00 AM and Nurse			6		1
	and shut the light off and did	î			
(4	ident #72's request for Resident #72 at a later time	i			1
	\$\text{\tin}\text{\tett}\text{\tett{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tin}\tint{\texi}\tint{\text{\text{\texit{\ti}\tint{\text{\tin}\tint{\tin}\tint{\text{\text{\texi}\tex	1			1
	d additional assistance from ue to having a wet brief and	*	ř		
a wet gown and did no		1	1		9
	d she had to change her	į			11 18
own wet gown without			Ti.		1
OWIT WEL GOWIT WILLIOUS	, assistance,		10		
A record review indica	ited the incident of neglect				30
	and the investigation into				
the allegation of negle		ł.	İ		
Executive Director was			İ		ì
investigation indicated			•		ì
suspended during the			•		1
4 (A)	vas unsubstantiated. The 24				1
Hour Initial Report was					1
	04/14/16 and the 5 Day	i i			
Director or muraing on	04/14/10 and the 5 Day	**************************************			8

	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
v		345447	B WING			. C	
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	07/29/2016	
1	No Nazir on our can			1	YNOLDS MOUNTAIN BOULEVARD		
EMERAL	RIDGE REHAB AND CA	RE CENTER		0/550000	EVILLE, NC 28804		
				_ AGITE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 225	Continued From page	10	, F	225			
	Working Report was s Director on 04/15/16.	signed by the Executive					
	On 07/28/16 at 3:40 F	PM a telephone interview	10.	200			
		staff member at the States'					
		t the HCPI had received a		1		1	
	24 Hour Initial Report		No.	4			
	Report for Resident #		(e ⁻¹	ď		ľ	
			(38)	1			
	On 07/28/16 at 4:25 P			3			
		ecutive Director (ED) who	()	i		1	
1	stated he was ultimate	전에도 ¹⁹⁸ 이 전에 있어 및 1980년 1일 전 1일 - 12등 1	35	3		!	
	•	I the 24 Hour Initial Report		i			
		ED stated the 24 Hour		4		i	
	A company of the comp	lent #72 was submitted 3	1				
	The state of the s	and was submitted along y Report. The ED assumed	3	1			
	[[[[[[] - '[[]]]]] [[] [[] - '[]] [[] [] [[] [] [] [] [[] [] [] [] []	e allegation of neglect for				3	
		d on 04/12/16. The ED	*	į			
	stated he had not date			Î		1	
		t for Resident #72 so he	į.	Ē			
a		that he conducted the		i			
1		stated he had shared the	1				
1		tting the 24 Hour Initial		t i			
		r Director of Nursing. The		1			
	ED stated he required	a better tracking system	Y.	i		!	
	for timely submission of the HCPI.	of the 24 Initial Reports to	e	İ		10 mm	
	483.13(c) DEVELOP/II		F 2	226 1)	Resident # 121 was seen by th	e	
SS=D	ABUSE/NEGLECT, ET	TC POLICIES		į.	physician on 7/28/2016. No n		
1	- No. of April 14 Contracts of Tracking Contracts			Ĭ		= vv	
	- 1000 M. M 1000 M 1000 M 100	op and implement written		-	orders noted.		
	policies and procedure			7	Nurse #3 was in serviced by the	e i l	
		and abuse of residents		111	Director of Clinical Services	1	
	and misappropriation of	iresident property.		100	on7/28/2016 and 7/29/2016 o	_	
Į.				1011			
					reporting any allegation of abu	se	
			0.53		and/or resident to resident		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		CONSTRUCTION		SURVEY
			40 No. 20 (20 (20 (20 (20 (20 (20 (20 (20 (20	102			С
		345447	B. WNG			07/	29/2016
	ROVIDER OR SUPPLIER O RIDGE REHAB AND CA	ARE CENTER		25	REET ADDRESS, CITY, STATE, ZIP CODE REYNOLDS MOUNTAIN BOULEVARD SHEVILLE, NC 28804	s. ?	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	This REQUIREMENT by: Based on record rev interviews the facility policy and procedure identification, and pro (Resident #121). The Findings include A policy titled "Subject revision date of 06/00 that may cause or cat psychological or emoticated by simple net Furthermore, the Adr recognizes that resid by other residents, vicemployee who witnest abuse or an allegation obligated to report su to their supervisor. If not available, the em designated Nursing St time of the event. Add immediately report to who is the designated or Director of Clinical notification to the res member, responsible the alleged, suspected neglect or mistreatment attending physician. It allegation of abuse of shall be segregated f investigation resident Clinical Nurse in char	iew, resident, and staff failed to follow their abuse in the areas of reporting, bection for 1:1 resident d: ct: Resident Abuse and had a 1/15 read in part: Any action uses actual physical, become a constitutes abuse. Ininistration of the Company ent abuse can be committed sitors, or volunteers. Any uses or has knowledge of n of abuse to a resident, is such information immediately the immediate supervisor is ployee is to notify the Supervisor on duty at the ditionally the supervisor must the Executive Director (ED), d abuse coordinator. The ED Services (DCS) will ensure ident's legal guardian, family party or significant other of d or observed abuse, ent, and notify the resident's	F	226	altercations. Nurse #2 was in serviced by the Director of Clinical Services on7/27/2016 on reporting any allegation of abuse and/or resident altercations. 2) All residents have the potential affected by this citation. Curre residents were interviewed reg abuse and any potential resider resident altercations on 7/27/2 with no negative findings. 3) The Executive Director and Director of Clinical Services were in servicent on the Abuse policy on 8/8/2021 the Regional Director of Clinical Services. Licensed Nurses, Cert Nurse Assistants, Housekeeping Dietary, Maintenance, Social Seausiness Office Manager, Human Resources, Admissions, Activities were in serviced by the Director Clinical Services and/or Nursing Supervisor on Abuse Policy, regallegations and resident to resident to resident to resident to resident Monitoring for reporting of resident to resident reporting of resident reporting reporting of resident reporting reporting reporting reporting reporting reporting reporting reporting reporting reporting reporting reporting reporting repor	dent to to be nt arding nt to 016 ector iced 16 by lified g, ervices, an es r of g oorting dent 016. cocial Quality	

and notify the attending physician. An incident

OLIVICI	OT OIT MEDIONITE a	MEDIOTID CENTICES				OIVID 110. 0330	0-0331
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A 1.50 10	TIPLE CON	ISTRUCTION	(X3) DATE SURVE COMPLETED	Υ
		345447	B. WING	· .		. C 07/29/201	10
NAME OF D	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	0/129/20	10
INAME OF F	NOVIDEN ON SOFT CIEN			201000107002	YNOLDS MOUNTAIN BOULEVARD		
EMERALO	RIDGE REHAB AND CA	ARE CENTER		1000000000000	VILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMP	X5) PLETICN ATE
F 226	226 Continued From page 12		· F	226	altercations and/or allegations of	.F	
1		y the individual in charge			abuse three times a week for for		
		ort in conjunction with the		70			
	person who reported				weeks, two times a week for fou		
					weeks and one time a week for I	our	
	Resident #121 was at 05/25/16.	dmitted to the facility on		10	weeks and or until substantial		
			× =	compliance is obtained then qua	ertarly		
		m Data Set dated 06/01/16			thereafter.	iterry	
	and was under Hospid	21 was cognitively intact		1		1	
		te care and required		4)	The Executive Director introduce	d the	
		ory failure, cardiopulmonary			plan of correction to the Quality	•	
		t-traumatic stress disorder,			Assurance Performance Improve	ment	
	psychotic disorder, an		85 980		Committee on 8/22/2016. The		
,	depression. Resident				results of this audit will be repor	• a d	
	requiring supervision						
		assistance with dressing,		V)	to the Quality Assurance Perforn		
	toileting, and persona	l hygiene.			Improvement Committee memb	ers	
,	A laur af a arras ala	anta assata d bu Nusan #0			monthly for three months then		
	and dated 07/17/16 at	note created by Nurse #2			quarterly thereafter for a year.	The	
		ated that his new roommate			Quality Assurance Performance	1.51.51	
•	became aggressive a				· ·	202	
	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	16. Resident #121 stated he			Improvement Committee memb	ers	
		bout his own safety at			consist of but not limited to the		
t	times.			9	Executive Director, Director of Cl	inical	
		Taxas van vi			Services, Unit Manager, Staff		
	On 07/26/16 at 8:51 A			2.5	Development, Activities, Medica	1	
		ent #121 who stated he had			Director, Social Services,	÷	
	been struck in the righ	121 stated he tried to move		ii.	The second secon		
		g struck by his roommate		1	Maintenance Director, Dietary	#3	
	1.52	le contact with Resident		-	Manager and Minimum Data Set		i.,
		and further stated if he had			Coordinator.	18/25	116
	not tried to move out of	of the way of his		3			
		would have received a		8			
1	harder strike. Residen			i			
		urse of the incident but	1				
	could not recall the na	me of the nurse. Resident	8			1	

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OLIVILI	10 OIT MEDIONITE &	WEDIGNID GENVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		345447	B. WNG			C
NAME OF F	PROVIDER OR SUPPLIER			CTOCK	ET ADDOCCO CITY STATE 310 CODE	07/29/2016
MAIL OF F	NOVIDER ON SOIT EIER			120000000000000000000000000000000000000	ET ADDRESS, CITY, STATE, ZIP CODE	
EMERALI	D RIDGE REHAB AND CA	ARE CENTER		V625283153	YNOLDS MOUNTAIN BOULEVARD	
				ASITE	EVILLE, NC 28804	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 226	Continued From page	: 13	F	226		
	7000000000 W to 300000 -0 0	ot been able to get any rest	•	,		i i
		mate wandering around the				
	and a mare mark that and being a market and order and	he thought approximately				1
		incident the facility moved				
		ne room. Resident #121				
	stated he thought the	facility should have moved				1
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	is room sooner because	٠,	•		
	Resident #121 had no	t felt safe with his	*	Ü		*
	roommate wandering	around in the room and	į			į
	getting into Resident #	f121's personal belongings.				*
	0-07/07/10 -140.45	DIA - 1 - 1 - 1 - 1 - 1		21		*
		PM a telephone interview	7: *			į
		urse #2 who stated he was #121 on 7/17/16 that his	20 Tr			
	roommate had becom			10		
		Friday evening and had		1		
		Resident #121 informed	1			
		mate had made contact				İ
		houlder and Resident #121	į	1		
		y from receiving the strike.		1		
		ent #121 had denied any				
i		Nurse #2 stated Resident				
	#121 had informed hin	n that Resident #121's	i	1		
1	roommate had become	aggressive and had been	1	75		
1	rummaging around in t	he room. Nurse #2 stated	19	!		l l
	the Social Worker (SW	f) who he believed was part				
!		nformed on 07/17/16 that	i	1		
9	Resident #121 was no		9	i		12
4		tated he did not remember	•	3		Î
3		SW if Resident #121 had		1		
i		mmate on 07/15/16. Nurse	1			
		med by the SW that the	1			
	incompatible roommate		â			
9	Resident #121 would b			8		
		and Director of Nursing				
1	- A (A)	e facility. Nurse #2 stated		Ψ.		1
	in his opinion Resident	STEEL STATE OF THE STATE OF ST		8		*
;	danger from his roomin	•	į.	i		
	staying in the same roo	om with his roommate until				1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
	345447	8 WNG		. C
NAME OF PROVIDER OR SUPPLIER		2 - 11	ET ADDRESS, CITY, STATE, ZIP CODE	07/29/2016
NAME OF PROVIDENCE ON SUCH EIGH			EYNOLDS MOUNTAIN BOULEVARD	
EMERALD RIDGE REHAB AND	CARE CENTER	1		
		ASH	EVILLE, NC 28804	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
1		1		10
F 226 Continued From pa	ge 14	F 226		l.
administration could	d address the roommate	87		
situation on Monda	y 07/18/16. Nurse #2 stated	59		į.
he should have info	rmed the DON that Resident			
#121 had informed	Nurse #2 that he had been			12
And the state of t	nate on 07/17/16. Nurse #2	10		ī
	he had not informed the			E
	lesident #121 had been struck			
by his roommate.		4		19
0 - 07/07/40 -1 2:2:	PM an interview was			ŀ
	SW who stated she was #2 on 07/17/16 that Resident			1
	tood over his bed during the	,		
	dent #121 awake. The SW			
. •	ecall that Nurse #2 had			
	esident #121 had been struck	,		1
	he SW stated she did not	1		
	07/17/16 that Resident #121			
	cerns with his roommate. The		,	
	e clinical portion of the			
	eeting on 07/18/16 the DON			<u> </u>
	at Resident #121 had been			
kept awake by his re	commate. The SW stated	30		
nothing was mentio	ned by the DON that Resident			
#121 had been stru	ck by his roommate. The SW			
stated the administr	ator and DON were aware			
that she was working	g on a roommate change for			14
Resident #121's roo	mmate. The SW stated	· · · · · · · · · · · · · · · · · · ·		
Resident #121 cam	e to the nurse's station to			4
The sign of the state of the st	mmate would be moved	į.		
	121 had not been able to get	İ		9
	ated Resident #121 had not			
	had been struck by his			
roommate.		_		
0.07107116 -1 4:05	PM an interview was			
• CONTRACTOR OF THE PROPERTY O	se Aide #3 who stated on			
	d 7:00 AM to 7:00 PM and			
; was informed by Re		ь		
was informed by the	SIGGIL IT LE L HIGH HIS			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
					, c
		345447	B. WING _		07/29/2016
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
				25 REYNOLDS MOUNTAIN BOULEVA	RD
EMERAL	D RIDGE REHAB AND CA	RE CENTER		ASHEVILLE, NC 28804	
74 N ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CODECTION
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 226	Continued From page	e 15	i F 2	226	
		evening 07/15/16 had been			
		sident #121's bedside table			
,	그 경기가 되었습니다 그래요 하다 그는 내는 내는 사람이 보다니	sked his roommate to go to		™ ∰	
		nt #121 stated his roommate			
		he shoulder. Nurse Aide #3	1		NE I
	The second secon	esident #121 was anxious			
	about staying in the sa				4
		tesident #121 kept the			
		vided the room, Nurse Aide			
	#3 stated she informe	ed Nurse #2 that Resident	4	8	
		by his roommate. Nurse			
		se #2 that Resident #121			9
		ommate be moved out of	ì		
	with the second control of the contr	roommate was getting into			
		onal belongings and his	à.	į.	
	roommate kept pulling	g the curtain back. Nurse			
		as present when Nurse #2			
		21 that Nurse #2 could not		i ·	
	remove the roommate	from the room and the SW		ſ	
	would have to make a	rrangements to move		•	•
	Resident #121's room			r I	
7	William St. Commission of the				
	On 07/27/16 at 5:13 P	M a telephone interview	30 10	į.	
		lurse #3 who stated she	ii.		<u> </u>
	worked on 07/16/16 fr	om 7:00 PM to 7:00 AM			i
	and was informed by F	Resident #121 that he had			ŕ
		ommate on 07/15/16. Nurse			į.
34	#3 stated Resident #1	21 informed her that his	į.	is a second of the second of t	
	roommate made conta	act with him but was not a		i	4
	direct hit. Nurse #3 sta	ated Resident #121	į.	3 427	i i
		ad told the SW that he had	į.		1
	han a selection and expression consideration of the contract o	mmate. Nurse #3 stated			
	she had not reported to				1
	Palatikalih namanan san - alian dan masas	ident #121 had been struck			1
		ruse she thought the SW	i	#0\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	¥
		I and administrator of the		I.	
		ted she had not completed			*
		ling Resident #121 being			1
	struck by his roommate	e because she believed a		g g	1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED
						С
		345447	B. WING			07/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE	
EMEDALL	RIDGE REHAB AND CA	DE CENTED		25 REY	YNOLDS MOUNTAIN BOULEVARD	
LINLIVALE	MIDGE NETIAB AND CA	NE OLIVIER		ASHE	VILLE, NC 28804	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	D		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION
F 226	Continued From page	16		226		
			1513	220		*
	concern form had alre	ady been completed.	44	į		l it N
	On 07/28/16 at 9:05 A	M an interview was		Î		
	conducted with the SV					
		t #121 had been struck by				XI
9		/27/16 and was not aware		ž.		#
		as struck by his roommate				II. W
	on 07/15/16 and she h	nad no knowledge of the				#} ==
	incident until 07/27/16	. The SW stated Nurse #2				i i
	had not reported to he	r that Resident #121 had		8		R
		mmale on 07/15/16. The				8
	[C-100]	of reporting resident to				
-		eeded to be fixed. The SW	9			į.
,		in that Resident #121 had				g .
		mmate on 07/15/16 she	2:			19
		sident #121's roommate	÷	1		ři B
	sooner.			- 1		
	An intensionary and and	history with the Disease of		1		
		lucted with the Director of b) on 07/28/16 at 9:54 AM				
	in meditir no nervane un encartation de la company en en militar en confinci	ents concerning residents				
1		finary than staff were to call				
		ited her expectation was		H		72
Ţ		her immediately of any	*			1
9		ercation and of any unusual	\$1			
		e DCS stated she had not		÷		1
25	been informed until 07	/27/16 that Resident #121				1
	had been struck by his	roommate. The DCS				1
	stated her expectation	was that a Situation	ř.			0.50
	Background Assessme	ent Recommendation				5
	(f.,	ave been filled out and a		*		1
		ould have been performed				4
	on 07/15/16 or 07/16/1					
i		en struck by his roommate				14
	as per facility protocol.		¥6			2
	expectation was that N					
		ely notified the DCS when				₫ 13
1		d Nurse #2 and Nurse #3				
	that he had been struc	к by nis roommate on		1		

						ONID NO. 0936-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 Later and 100 and		ISTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILD	NG		COMPLETED
						С
		345447	B WNG			07/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
EMERALI	D RIDGE REHAB AND CA	RE CENTER	3	25 RE	YNOLDS MOUNTAIN BOULEVARD	
	o mode members	THE SERVICE		ASHE	EVILLE, NC 28804	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI	K	(EACH CORRECTIVE ACTION SHOULD E	BE COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
	1				DEFIGIENCY)	
F 000	1	v_	!	4		
F 226	Continued From page		i F	226		
		ated her expectation was				t.
		rse #3 would have informed		3		1
		nd the Executive Director	T.	1		
	that Resident #121 ha	E.	i			
		stated if she had known that				
		en struck by his roommate				
		diately came to the facility				!
		nts to have Resident #121's				¥ .
	roommate relocated to		1			
	facility. The DCS state		1	₽		¥
		ident to resident abuse. The	j			ř l
		found out on 07/27/16 that	3			i
		en struck by his roommate	ì			Į.
	implemented on 07/27	ne incident was immediately	1			
	implemented on 07727	710	Ì	ĭ		i i
	An interview was cond	fucted with the Executive				1
		3/16 at 11:28 AM who stated		<u>\$</u> 6		
11.		7/27/16 by another staff	x			
		#121 had been struck by	Ď			"
) stated he was unaware		68		E ¹
	that Resident #121 ha		-	23		
;	roommate until 07/27/			i		
	expectation was that the			5.03		
		ely that Resident #121 had				
		mmate. The ED stated the				12.00 13
	facility policy indicated					2 . 83
74	The second of the second secon	ent, or any abuse was to be				<u> </u>
	immediately reported t	o the ED. The ED stated		1		1
52	he never received a wi	ritten report that Resident				4
	#121 had been struck	by his roommate. The ED		1		120
		ad not been notified that	±9	ï		i
12		en struck by his roommate				
	at the time of the incide	ent.		(d (d		j
				1		(9
		M a telephone interview				84 85
		urse #2 who stated he had				84.0 19
		cian on 07/17/16 when				B
	Resident #121 had info	ormed Nurse #2 that he				1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIF A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED		
		345447	B. WING			5.	C 29/2016	
	ROVIDER OR SUPPLIER D RIDGE REHAB AND CA	RE CENTER		25 RE	T ADDRESS, CITY, STATE, ZIP CODE YNOLDS MOUNTAIN BOULEVARD VILLE, NC 28804	011	25/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	i.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 250 SS=D	performed a nursing at On 07/29/16 at 7:20 A conducted with Nurse when she was informed had been struck by his notified the physician Nurse #3 stated she to already notified the phad been struck by his 483.15(g)(1) PROVISI RELATED SOCIAL SETTHE facility must proviservices to attain or more practicable physical, in well-being of each resulting the physical of the physical of the facility failed f	s roommate and had not assessment. M an interview was #3 who stated on 07/16/16 and by Resident #121 that he is roommate she had not or a nursing assessment. Inought someone else had assician that Resident #121 is roommate. ION OF MEDICALLY ERVICE Ide medically-related social aintain the highest mental, and psychosocial ident. Is not met as evidenced assigned as a staff interviews the led to address the residents mappropriate elimination avior and emotional status dent for behavior and	F 25	The second secon	Resident #155 no longer resides the facility. The Social Services Director performed Quality Improvement Monitoring of current residents any psychosocial needs for their wellbeing, and any concerns for residents with behaviors 8/17/20 8/24/2016. The Regional Director of Clinical Services in serviced the Director Social Services on providing psychosocial services to meet the residents wellbeing and how to	other D16-		
	The findings included:			E	follow up with residents with behavior's and update care plans	to		
Ī	unit that was not locke diagnoses which include	ded blood clots of the deep emity, muscle weakness,	· · · · · · · · · · · · · · · · · · ·		reflect specific interventions for tresidents with behaviors 0n 8/23/2016. Licensed Nurses,			

OLIVILIY	STOR WEDICARE &		T	-			3. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	the same and the		CONSTRUCTION		SURVEY PLETED
		245447	B. WNG				C
		345447	B. WING			07	/29/2016
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EMERALD	RIDGE REHAB AND CA	RE CENTER			5 REYNOLDS MOUNTAIN BOULEVARD		
				ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 250	A review of the admission Minimum Data Set (MDS) dated 07/19/16 indicated Resident #155 was severely impaired in cognition for daily decision making and had physical behaviors directed toward others which occurred 1-3 days, verbal behaviors directed toward others which occurred 1-3 days and rejection of care which occurred 1-3 days. The MDS also indicated Resident #155 required extensive assistance with dressing, toileting, hygiene and transfers but limited assistance with locomotion on the unit. A review of documents from a previous facility with a facsimile (fax) stamp dated 07/12/16 at 8:50 AM contained notes by a Social Worker (SW) indicated Resident #155 lived on a secured Alzheimer's unit for a more structured and secure environment. A review of an Admission Data Collection form which included the nursing admission assessment dated 07/12/16 at 3:30 PM revealed Resident #155 was disoriented to person, place and time at all times. The form also revealed			250	Certified Nurse Assistants, Housekeeping, Dietary, Maintenan Social Services, Business Office Manager, Human Resources, Admissions, Activities were in serviced by the Director of Clinical Services and/or Nursing Superviso on Abuse Policy, reporting allegati and resident to resident altercatio 8/15/2016-8/24/2016. The Execut Director and or Social Services Director will perform Quality Improvement Monitoring for reporting of resident to resident altercations and/or allegations of abuse three times a week for four weeks, two times a week for four weeks and one time a week for four obtained and then quarterly	ons ns ve	
		The form also revealed risk for elopement and had			thereafter for one year. The Social	ı	
		which included wandering,			Services Director will monitor		
	resisted care and had				residents with behavior's for residents	ent	
	A	ion Coro Dian datad		ĺ	specific interventions and for resid		
	A review of an Admiss	following approaches:				CIII	
		eded, always ask for help if			psychosocial needs three times a		
	resident was abusive				week for four weeks, two times a		
	environment calm and				week for four weeks and one time	1000	
	public area if behavior is improper and encourage diversional activities. There were no handwritten notes related to any specific behaviors or interventions for staff to attempt.				week for four weeks until substan		
					compliance is obtained and then		
					quarterly thereafter for one year.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	File and the second second	(X2) MULTIPLE CONSTRUCTION A BUILDING			E SURVEY PLETED
		345447	B. WNG				C
	PROVIDER OR SUPPLIER D RIDGE REHAB AND CA			25	TREET ADDRESS, CITY, STATE, ZIP CODE 5 REYNOLDS MOUNTAIN BOULEVARD SHEVILLE, NC 28804	1 07	//29/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	· i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
	PM documented by N #155 was re-directed resident rooms and has personal things. A review of a nurse's real AM documented by Nicalled to Resident #15 (NA) and Resident #15 roommates side of the roommates bed and we small amount in the flor roommates bed and we roommates head and indicated Resident #15 bathroom by 2 staff. A review of a nurse's rependence of the roommates head and indicated Resident #15 was confused an notes further revealed to redirect and became and wandered in and of the resident's rooms. A review of a nurse's rependence has the resident's rooms. A review of a nurse's rependence has the resident's rooms. A review of a nurse's rependence has the resident's rooms. A review of a nurse's rependence has the resident's rooms. A review of a nurse's rependence has the resident's roommate. A review of a nurse's rependence has the resident's roommate.	note dated 07/12/16 at 9:00 urse #1 indicated Resident frequently from other id rummaged through their note dated 07/13/16 at 5:45 urse #1 indicated she was 5's room by a Nurse Aide 55 was standing on his room between his all and had urinated a nor at the head of his as about to urinate on his face. The notes further 55 was redirected to the note dated 07/14/16 at 7:30 urse #4 revealed Resident d was easily agitated. The Resident #155 was difficult angry with staff and family but of other resident rooms. ote dated 07/16/16 during M shift revealed Resident re-directing and cueing the wandered in and out of ote dated 07/17/16 at 1:00 rse #2 indicated Resident	F 2	250	4) The Executive Director introduce plan of correction to the Quality Assurance Performance Improvement Committee on 8/22/2016. The of this audit will be reported to Quality Assurance Performance Improvement Committee members and the quarterly thereafter for a year. Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Conservices, Unit Manager, Staff Development, Activities, Medica Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	y rement results the pers The pers	8/25/16

	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	51
					С	
		345447	B WNG_		07/29/2016	
NAME OF P	ROVICER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
FMERALI	RIDGE REHAB AND CA	DE CENTER		25 REYNOLDS MOUNTAIN BOULEVARD	٥	
LIILIAA	NIDOL NEIMO AND GA	INE CLITTEN		ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION	ч
F 250	Continued From page	21	, F 2		si.	
			F 4	50	1	
		is roommate's bed while his the room and had spilled				
		the room and had spilled edside table all over his		i	1	
		edside table all over his notes further revealed		<u> </u>	i	
		mate's bed linens were all		(8)	4	
		#155 had been drinking his	ř.		4	
	roommates left over in			•	•	
	100mmates left over 10	te tea.		i		
	A review of nurse's no	otes dated 07/19/16 at 11:35		8		
, and		urse #7 revealed Resident			4.	
i		and wandered into other			1	
9		went through their personal			g!" ()	
	things.	went unough their personal			i	
	tilligs.					
	A review of a Social So	anicae Admission			1	
		9/16 by the facility SW				
1		55 had no short term or		46	ar ar	
2					2	
	long term memory rec					
		or daily decision making			8	
*		ade decisions. A section			31	
į	labeled mental health			ā	1	
		ncerns was indicated yes			•	
		e indicated Alzheimer's			1	
		peled resident anticipated			1	
ţ		ed long term care - secured			1	
	unit.			₩ ₩	// //	
		W W WEST CONTROL OF THE CONTROL OF T	9		*	
	A review of a Care Are		14		1	
	worksheet dated 07/25	에 - '12이상 [12:16] . [[] . [] . [] . [] . [] . [] . [] . [] . [] . [] . [] . [] . [] . [] . []			18 22	
	Social Worker (SW) re	vealed behavioral			i	
	symptoms triggered du		1	5 e e e e e e e e e e e e e e e e e e e	1	
		ce of at least 1 behavioral	:		<u>u</u>	
i	symptom.			*	1	
i						
	During an interview on					
		ng staff talked to Resident		ı	* #	
		act him but at least half the				
	time he rummaged thro					
	things and exhibited be	ehaviors. She further				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A BUILDI	IPLE CONSTRUCTI	ON	(X3) DATE SURVEY COMPLETED
		345447	B. WING			C 07/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRE	SS. CITY, STATE, ZIP CODE	0772372010
EMERALO	RIDGE REHAB AND CA	RE CENTER		25 REYNOLDS	MOUNTAIN BOULEVARD	
				ASHEVILLE, I	NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K (EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 250	Continued From page	22	F.:	250		e E
	on a sometime control of the control of the	ess Resident #155 for	1000 2	İ		
		e thought that had already		21		y
		d not notify Resident #155's				1
		viors because she thought	,	45		
	that had already been					i
				Ĩ.		i
		n 07/29/16 at 9:21 AM	*			
		esident #155 was difficult to				10
		in the floor. She stated it				
		direct Resident #155 each				6
		ersional activities but that		*		
		had tried to monitor him at		20		
	the nurse's station but wander off.	the would get up and				j i
	wander on,					
	During an interview or	07/29/16 at 8:57 AM the				
		nt to Resident #155's room	·	•		7.
		he was admitted because		CE.		
		e had wandered in other		v		i
	resident's rooms. She	stated she was not aware				-
	of all the behaviors Re	esident #155 had exhibited				į.
		admitted to the facility he	* *			ļ i
	would adjust and would					i
	surroundings. She sta					£
		er informed about Resident				¥ì
	#155's behaviors but s			ę. W		¥0
		volved with assessing and		20 20		į l
	monitoring resident be	Haviors.				2
	During an interview or	07/29/16 at 2:42 PM the				ř.
		rvices stated it was her		ė.		ľ
		g staff to assess resident				
		nicate with the physician or				
		resident was continuing to				E
		e stated it was also her				£1
		V to assess and monitor	1			7. 10 13
		al well-being and behaviors		<u> </u>		<u>}</u>
	on admission and ther	n on a routine basis.)) []
						1

CTATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) AU II	TIDIE	CON	STRUCTION	(72)	DATE CUDICU
	F CORRECTION	IDENTIFICATION NUMBER.	A. BUILD			Second and Control of the Control of		DATE SURVEY COMPLETED
			7.00.25					C
		345447	B. WING				•	07/29/2016
NAME OF P	PROVIDER OR SUPPLIER			S	TREE	T ADDRESS, CITY, STATE, ZIP CODE		
EMEDALL	D RIDGE REHAB AND CA	DE CENTER		25	REY	NOLDS MOUNTAIN BOULEVARD		
CINICIOALI	D RIDGE REHAB AND CA	INC CENTER		Α	SHE	VILLE, NC 28804		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 253	Continued From page	23		253				a
	483.15(h)(2) HOUSE		21 22	253 253	11	The Adelance of	reneral es	1
	MAINTENANCE SER		г	255	1)	The Maintenance Director repai		1
33-E						the broken and/or splintered do	or	
	The facility must provi	ide housekeeping and				laminate on room #102 on		9
		necessary to maintain a				8/15/2016.		
	sanitary, orderly, and	comfortable interior.				The Maintenance Director repair	red	1
						the broken and/or splintered do		i
	This REQUIREMENT	is not met as evidenced				laminate on room #105 on	٠.	8
	by:		i .			8/15/2016.		
		ns and staff interviews the	*	1				
		resident doors with broken	3	ì		The Maintenance Director repair		2
	resident rooms in the	te and wood for 6 of 12	i			the broken and/or splintered do	or	
		#105, #107, #108, #110	:	1		laminate on room #107 on		
		pair damaged wood and	2	- 1		8/15/2016.		1
		of 2 of 2 smoke prevention	. f.	-		The Maintenance Director repair	ed	1
	i e	mentia unit, failed to repair	ŧ			the broken and/or splintered doc	or	
		ail in the main hallway		#0 50		laminate on room #108 on		
	dementia unit, failed to	room #102 in the locked		i i		8/15/2016.		i
		lets in 4 of 12 Resident				The Maintenance Director repair	لد	1
		ed dementia unit (Resident						į.
	bathroom #102, #105,	#108 and #110) and failed		1		the broken and/or splintered doo)r	
	to repair the baseboar		±			laminate on bathroom door and		
		that had separated from the	5 2			resident room door on room #11	0 on	ı i
14	dry wall in 1 of 12 residuals locked dementia unit.	dent bathrooms in the		1		8/15/2016.		
	locked dementia unit.			531		The Maintenance Director repair	ed	:
	The findings included:					the broken and/or splintered doc	r	1
				121		laminate on room #114 on	wite	
		Room #102 on 07/25/16 at		181		8/15/2016.		1
	A SECTION OF THE PROPERTY OF A SECTION OF THE PROPERTY OF THE	door of the resident's room		3		The Maintenance Director repaire	0.4	l l
	of the bottom half of th	ered laminate on the edges						21 E
		6/16 at 8:57 AM revealed		8		the smoke barrier broken and/or		
	the door of resident ro	om #102 had broken and				splintered door on the locked		
		the edges of the bottom				dementia unit on 8/15/2016.		
	half of the door.		693 N					Ĩ

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345447	B WNG_		*	C 07/29/2016
NAME OF PROVIDER OR SUPPLIER EMERALD RIDGE REHAB AND CARE CENTER (XA) ID. SUMMARY STATEMENT OF DEFICIENCIES		ID	25 REY	T ADDRESS, CITY, STATE, ZIP CODE NOLDS MOUNTAIN BOULEVARD VILLE, NC 28804 PROVIDER'S PLAN OF CORRECTION	(72)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
F 253	the door of resident rosplintered laminate or half of the door. b. Observations of Rosponson of Polymon and bathroom half and bathroom half of the doors of resident robservations on 07/22 the doors of 12 the doors of 12 the doors of 12 the doors of 13 the bottom half of the Doservations on 07/22 the doors of resident robservations of 13 the doors of resident rosplints of 14 the doors of 14 the doors of 15 the	7/16 at 9:15 AM revealed from #102 had broken and the edges of the bottom om #105 on 07/25/16 at doors of the resident's ad broken and splintered of the bottom half of the 6/16 at 8:59 AM revealed from and bathroom #105 ared laminate on the edges from and bathroom #105 ared laminate on the edges from and bathroom #105 ared laminate on the edges for edges are doors.	F 25	3	The Maintenance Director repair the vinyl hand rail across from resident room #102 on 8/16/2017. The Maintenance Director and/o Housekeeping Supervisor repaire the grout in the bathroom #105/8/16/2016. The Maintenance Director and/o Housekeeping Supervisor repaire the grout in the bathroom #108/8/16/2016. The Maintenance Director and/o Housekeeping Supervisor repaire the grout in the bathroom #108/16/2016.	ed on or ed on or
	5:18 PM revealed the had broken and splints of the bottom half of the Observations on 07/26 the door of resident rosplintered laminate on half of the door. Observations on 07/26 the door of resident rosplintered laminate on half of the door. d. Observations of Rosplintered laminate on half of the door. d. Observations of Rosplintered laminate on half of the bottom half of the bottom half of the bottom half of the Observations on 07/26 the door of resident rosplints of the bottom of resident rosplints of rosplints of the bottom of resident rosplints of rosplints of the bottom of resident rosplints of r	6/16 at 9:09 AM revealed om #107 had broken and the edges of the bottom 7/16 at 9:20 AM revealed om #107 had broken and the edges of the bottom om #108 on 07/25/16 at door of the resident's room ered laminate on the edges		2)	The Maintenance Director repair the baseboard in resident room on 8/16/2016. The Maintenance Director and/or Housekeeping Supervisor observed doors for broken laminate, spline wood, loose baseboards, and grorestrooms for cleaning and repair 8/15/2016-8/24/2016. Issues identified were repaired by the Maintenance Director and/or Housekeeping Supervisor. The Executive Director in service Maintenance Director and the Hokeeping supervisor on maintaining	#110 or ved tered out in ir d the

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CENTER	S FUR WEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345447	B. WNG			, C
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	07/29/2016
					REYNOLDS MOUNTAIN BOULEVARD	
EMERALI	O RIDGE REHAB AND CA	RE CENTER			HEVILLE, NC 28804	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 253	Continued From page	25	F	253	hand rails, doors and grout on	
	half of the door.			233		i
		7/16 at 11:20 AM revealed			8/19/2016. The Director of Cli	
		om #108 had broken and			Services in serviced licensed n	100-1 - 000-100-100
		the edges of the bottom			certified nurse aides on notifyi	ng
	half of the door.				Maintenance should they find	any
	a Observations of Ro	om #110 on 07/25/16 at			area that needed repair 8/15/2	2016-
		rs of the resident's room	(()		8/24/2016. The Maintenance (Director
	and back of bathroom	door had broken and		•5	and/or Housekeeping Supervis	The state of the s
		the edges of the bottom		-	perform Quality Improvement	
	half of the doors.	5/16 at 9:19 AM revealed			Monitoring of resident room d	
		oom and back of bathroom			bathroom doors for broken or	
		en and splintered laminate		1		!
	on the edges of the bo			i	chipped laminate or wood,	Ĭ
1		716 at 11:25 AM revealed from and back of bathroom		i	baseboards in need of repair,	ř.
1		en and splintered laminate	i	3	handrails in need of repair and	
1	on the edges of the bo		30	3	in need of repair three times a	
(8))			¥	for eight weeks, two times a we	eek for
		m #114 on 07/25/16 at			four weeks until substantial	i b
		door of the resident's room red laminate on the edges	×		compliance is obtained and the	121
	of the bottom half of th	A CONTRACTOR OF THE CONTRACTOR		1	quarterly thereafter for one year	ar.
1	Observations on 07/26	/16 at 9:29 AM revealed		4)	The Maintenance Director intro	oduced
-		om #114 had broken and		8	the plan of correction to the Qu	Jality
		the edges of the bottom			Assurance Performance Improv	rement
	half of the door. Observations on 07/27.	/15 at 11:30 AM revealed		ř	Committee on 8/22/2016. The	
		om #114 had broken and		1	results of the audit will be repo	i 1
	, 맛있다면 어디어 가게 되었다. 그 아이는 아이는 그리고 있다.	the edges of the bottom	#) Fil		the Quality Assurance Bank	rted to
į	half of the door.			Ē	the Quality Assurance Performa	ince
i 90	2 a Observations of a	set of smoke barrier doors		4	Improvement Committee mem	bers
		unit on 07/25/16 at 5:15		343	monthly then quarterly thereaf	ter for
		ith broken and splintered			a year. The Quality Assurance	
	laminate on the edges	of the lower half of each	(4))		Performance Improvement	
	door. Observations on 07/261	16 at 9:35 AM revealed		8	Committee members consist of	but
	COSELVATIONS OF OTTAN	ID ALS 33 ANT LEVERIED				12

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		345447	B. WNG		07/29/2016	
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EMERALD RIDGE REHAB AND CARE CENTER			2	REYNOLDS MOUNTAIN BOULEVARD		
LINCIALD	MIDGE REPROPERTY	THE SERVICE	A	SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCEO TO THE APPROPRI DEFICIENCY)		
F 253	Continued From page		· F 253	not limited to the Executive Direct	or,	
		rs in the locked dementia		Director of Clinical Services, Unit		
i :		plintered laminate on the		Manager, Staff Development,		
- 4	Observations on 07/27	r or each door. 7/16 at 11:35 AM revealed		Activities, Medical Director, Social		
		rs in the locked dementia		The second control of the second seco		
		plintered laminate on the	¥3	Services, Maintenance Director,	i	
	edges of the lower hal			Dietary Manager and Minimum Da	ita i i	
	<i>M</i> .			Set Coordinator.	2./25/16	
		he vinyl hand rail across				
		02 in the main hallway of	1 1		i	
		nit on 07/25/16 at 5:20 PM			•	
	Taking the second secon	ped crack on the front side	190		ľ	
	of the hand rail that wa				70. 465	
		6/16 at 9:40 AM of the vinyl			1	
	hand rail across from r		1			
		ped crack on the front side			ħ	
	of the hand rail that wa	7/16 at 11:40 AM of the vinyl			0	
•	hand rail across from r	The state of the s	1			
100		ped crack in the front side				
	of the hand rail that wa	**************************************	1			
į.	or mo mana ran mar mo		í			
10	4. a Observations in th	e bathroom of Resident			į	
18	room #102 on 07/25/16	6 at 5:07 PM revealed dark,	i		1	
	brown stains in the gro	ut around the base of the	1			
	toilet.		1		ļ	
1.5	Observations on 07/26				1	
		oom #102 revealed dark	-		1	
1	[전:1 [- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	ut around the base of the	Î			
	toilet.	10 -1 0-17 AM to the	1			
	Observation on 07/27/	oom #102 revealed dark	1			
		ut around the base of the	1			
	toilet.	of around the base of the			!	
1	ionat.		4		2.	
	b. Observations in the	bathroom of Resident				
		at 5:03 PM revealed dark,				
		ut around the base of the				
	toilet.				Î	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		345447	B. WNG	B. WING		C 07/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	0//23/2010
EMERAL	D RIDGE REHAB AND CA	RE CENTER		0.000000	REYNOLDS MOUNTAIN BOULEVARD	
A STATE OF THE STA	87.32811B 20000 NONEMBER WAS ASSESSED.			ASI	HEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 253	Continued From page	27	F	253		
	Observations on 07/2	6/16 9:02 AM in the	y.			1
		room #105 revealed dark				1
	toilet.	out around the base of the				
	Observation on 07/27		4			
		room #105 revealed dark out around the base of the	7	i		
	toilet.	Jul alound the base of the				
	- Observations in the	bathroom of Resident		st		
		6 at 4:47 PM revealed dark.		1		
		out around the base of the		*		Ì
i	toilet.	fill The The Market Consideration		,		
	Observations on 07/26					
		room #108 revealed dark				
	brown stains in the gro toilet.	out around the base of the		ï		
	Observation on 07/27/	/16 at 9:22 AM in the		8		
		oom #108 revealed dark				b
	The state of the s	out around the base of the				
ĺ	toilet.			æ		
	d Observations in the	bathroom of Resident				
		6 at 4:47 PM revealed dark,		Ì		
		out around the base of the		1		ě
	Observations on 07/26	3/16 9:08 AM in the				i .
		room #110 revealed dark		*		i
		out around the base of the		*		
58	toilet.					i
	Observation on 07/27/					
		oom #110 revealed dark				
	toilet.	out around the base of the				·
	tolict.			ļ		!
4	5. a. Observations in the	he bathroom of Resident		*		į
		6 at 4:47 PM revealed the		•		***
	baseboard along the w toilet had pulled away	vall on the right side of the from the dry wall and		#1 #2		

	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER.	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
100		21212			С
		345447	B. MNG		07/29/2016
NAME OF P	ROVICER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE
EMERALD	RIDGE REHAB AND CA	RE CENTER		25 REYNOLDS MOUNTAIN BOULEVAR	(D)
Lillaroilla	THE CENTENNE WITE ON	THE SERVICE		ASHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
E 252	Continued From Tone	00			
1 200	Continued From page		F:	253	
		along the line where it had	,		<u> </u>
	separated from the wa			8	
	Observations on 07/26				į
		oom #110 revealed the		*	*
	toilet had pulled away	vall on the right side of the			£
	the second contract of the second second second second second second second second second second second second	along the line where it had			
	separated from the wa				<i>™</i>
	Observation on 07/27/			ř.	·
		oom #110 revealed the		2	
		vall on the right side of the	į		
	toilet had pulled away				
1		along the line where it had			1
I	separated from the wa	II.			12
,				E E	i i
	An interview and envir		B		
		d dementia unit with the			
	Maintenance Director			1	£
		The Maintenance Director		č.	D
		a work order system and			Đ.
;		black box that was labeled		6	
14		se's station. He explained		1	Đ.
		fill out the work order with and sign it and place it in			
		assistant made rounds			
4	throughout the day to d			846	1
		stopped him in the hall to			*
(4		at needed to be fixed. He	9		
25	confirmed he was not v				:+-
		time because they had just			841
9	finished painting in the	facility. During the tour he			14/1 14/1
	acknowledged the splir	ntered doors on resident	13	9	787
		smoke protection doors		•	4
		d to be sanded and some			
		outty applied. He stated he			8
	had not received any w				
		onfirmed the hand rail was			
		llway of the dementia unit	9		8
	across from Resident F	Room #102 and stated he	¥		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345447	8. WNG			, C 07/29/2016	
	ROVIDER OR SUPPLIER O RIDGE REHAB AND CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 25 REYNOLDS MOUNTAIN BOULEVAL ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ς .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
F 278 SS=D	to be replaced around rooms #102, #105, #1 not received any work confirmed the basebo wall in the bathroom of he was unaware it had buring an interview of Administrator explaints would go through ever the repairs. He stated staff saw things that no report them to him or Director. He further stated was a potential sathould report it immed 483.20(g) - (j) ASSES ACCURACY/COORD The assessment must resident's status. A registered nurse must each assessment with participation of health A registered nurse must assessment is complete that portion of the assessment must sign that portion of the assessment must sign that portion of the assessment in a registered and knowingly false statement in a registered in a registered and knowingly false statement in a registered in a registered and knowingly false statement in a registered in a registered and knowingly false statement in a registered in a registered and knowingly false statement in a registered in a registered in a registered and knowingly false statement in a registered in a	de verified the grout needed I the toilets inn Resident 08 and #110 and he had a orders to repair these. He ard had separated from the of Resident room #110 and d happened. In 07/29/16 at 4:40 PM the ed the Maintenance Director ry doors and toilet to make it was his expectation if eeded repair they should to the Maintenance tated if staff saw anything afety hazard report staff diately. SMENT INATION/CERTIFIED It accurately reflect the est conduct or coordinate in the appropriate professionals. In ompletes a portion of the each certify the accuracy of essment. Medicaid, an individual who certifies a material and	F 2	253		or ed In ors s and	
	assessment must sign that portion of the ass Under Medicare and M willfully and knowingly false statement in a re	and certify the accuracy of essment. Medicald, an individual who certifies a material and isident assessment is		3)	The Social Services Director was inserviced on completing accurate CAA's related to resident behavior with Identifying specific strengths	ors s and	

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OLITICI	TO TOTA MEDICANE &	MEDICAID SERVICES				OMB N	NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION		NTE SURVEY
		345447	B. WNG				С
NAME OF E	PROVIDER OR SUPPLIER	040447	D. MINIO	0.00		0	7/29/2016
1474AL OF F	MOVIDER OR SUFFICE			5570-06	ET ADDRESS, CITY, STATE, ZIP CODE		
EMERALI	D RIDGE REHAB AND CA	RE CENTER		HACTER OF	EYNOLDS MOUNTAIN BOULEVARD		
				ASH	EVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278		30 ssment; or an individual who causes another individual	F	278	Mix/MDS Coordinator on 8/22/2 The Director of Clinical Services	2016.	
	to certify a material ar	d false statement in a			and/or the Minimum Data Set		
		s subject to a civil money			Registered Nurse will audit CAA'	s of	
	penalty of not more th				residents with behavior's based		
	assessment.				the MDS schedule for accuracy t		
	Olisiaal disassessesses	J			times a week for twelve weeks o		
	Clinical disagreement material and false stat			1/2 38		ľ	
W	material and laise stat	ement.			until substantial compliance is		
	by: Based on record reviefacility failed to accura psychosocial problems strengths and weakne psychosocial status for Care Area Assessments. The findings included: Resident #155 was add 07/12/16 with diagnose clots of the deep veins muscle weakness, lack pain and Alzheimer's dadmission Minimum Da 07/19/16 indicated Resimpaired in cognition for and had physical behard others which occurred directed toward others and rejection of care with the accurred the MDS also indicate.	mitted to the facility on es which included blood of left lower extremity, to foodination, low back isease. A review of the eata Set (MDS) dated daily decision making wiors directed toward 1-3 days, verbal behaviors which occurred 1-3 days. d Resident #155 required		4)	obtained then quarterly thereaf for one year. The Executive Director introduce plan of correction to the Quality Assurance Performance Improve Committee. The results of this a will be reported to the Quality Assurance Performance Improve Committee members for 6 mont and/or until compliance is obtain The Quality Assurance Performal Improvement Committee members for but not limited to the Executive Director, Director of Cl. Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.	ed the rement audit ement ths ned. nce ers	
4	extensive assistance w hygiene and transfers to locomotion on the unit	ith dressing, toileting, out limited assistance with	3				ı

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С
		345447	B. WING _			07/29/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP CODE	
EMEDILO	מומסב מבווע מ נעום מי	IDE OCNITCO		25 REYNOLDS	S MOUNTAIN BOULEVARD	
EMERALL	RIDGE REHAB AND CA	ARE CENTER		ASHEVILLE,	NC 28804	
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CRO	DSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE
F 278	Continued From page	31	F 2	78		
	A review of a Care Ar	ea Assessment (CAA)		1		
		5/16 completed by the				
	Social Worker (SW) r		0			
	The second secon	lue to rejection of care;				i
,		nce of at least 1 behavioral		15		F.
		f the sections listed in the		1		
	CAA worksheet indica			l .		
	a. Analysis of Finding	s indicated "Actual" and a	1	5		i .
	section labeled seriou	sness of the	î.			į.
,	problem/condition ind	icated progressive	i			
	dementia.					i
	b. Nature of the behav	vioral disturbance (resident				1
	interview, if possible of	or staff observations)				i
134	revealed nothing was	checked or documented.	1	51		r: 9
9	c. Medication side effe	ects that can cause				į
3	behavioral symptoms	revealed nothing was		_8		
1	checked or document	ed.		1		
	d. Illness or conditions	s that can cause behavior		4		(30)
	problems indicated pa	in was checked.				1
	e. Factors that can ca	use or exacerbate the		46		
	behavior revealed not	hing was checked or	2			(2)
98	documented.			(9)		1
	f. Cognitive status pro	blems indicated Alzheimer's	0			· · · · · · · · · · · · · · · · · · ·
	disease and a section	labeled other		;		1
	considerations revealed	ed nothing was checked or		i		
3	documented.			2.5 2.5		į.
	g. Will behavioral sym	ptoms and functional status	ř	(9)		ì
	be addressed in the c	are plan? The	£ .	1		
5.0	documentation indicat					
92		this problem, what is the				\$
	A STATE OF THE PARTY OF THE PAR	areas checked included				
	그러워 가는 그러워 없었다. 이렇게 그러는 바로 맛이 모든 그 등이다.	minimize decline, avoid				
	complications, mainta					•
	functioning and minim					P.
		he problem/need on the				
	resident and your ratio			9		
		nplications and risk factors				-
	and the need for refer	ral to other health				*

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345447	B. WNG		С
NAME OF P	ROVICER OR SUPPLIER	0.01.11	1	PIDEST ADDRESS OFFI STATE TO SORE	07/29/2016
	NO VIGEN ON GOVE EIGH			STREET ADDRESS, CITY, STATE, ZIP CODE	
EMERALD	RIDGE REHAB AND CA	RE CENTER		25 REYNOLDS MOUNTAIN BOULEVARD	
				ASHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE COMPLETION
E 070					ī
F 278	Continued From page	32	, F2	278	
	professionals) reveale	ed the following: related to	\$		
	the resident's diagnos			Î	2
	25 VEST 10 VES	gnitive decline and would	2		8
		symptoms of an acute			i
		ut would not proceed to care			Ď
	plans at this time.		3		
		ferral to other disciplines			
	indicated psychiatric s	ervices.			(0
	During an intension or	1 07/29/16 at 2:42 PM with			
		Services she stated she			₩ 2
		worksheets but she was		80	
		S or CAA summaries or			i i
	worksheets.	0 01 01 0 0011111111100 01			Ĕ
1.5			;	T .	
		07/29/16 at 8:57 AM the			
	SW confirmed she had	d completed the CAA		i	
		rs. She stated she had not		•	
		g in completion of the CAA			
		een trained by the person	7	1	1
		preceded her. She further	I.	1	•
		sessed Resident #155's	i	i i	1
	(c) (c)	nd had relied on nursing	!	1	: 1
	- 100명(GPA) 10 - BANK : [[[[[[[]]]]] - [[[]]] [[[]] [[]] [[]]	cerns to her. She stated dhave assessed Resident	1		
		ne could have included the		*	
	information on the CA		1	¥ 31	3
1	information on the C/V	(Worksheet,	300	1	9
	During an interview on	07/29/16 at 4:05 PM the			1
		irmed the CAA worksheet		*	1
	for behaviors complete			i i	i
	contain an accurate as		4	•	
	#155's psychosocial st	atus or behaviors. He		i	
		e the CAA worksheet did		2	i.
	not contain an accurate	e assessment for			
	psychosocial status an				
		e she had not received any	a	*	J.
	formal training on comp or worksheets.	pletion of CAA summaries		Nicotal Maries	и

STATEMENT OF DEFICIENCIES (X1) PROVIDENZUPLIER/CLIA		(X2) MULT		(X3) DATE SURVEY COMPLETED				
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _				0
		345447	B. WING					29/2016
	ROVIDER OR SUPPLIER RIDGE REHAB AND CA			ST 25	REY	ADDRESS, CITY, STATE, ZIP CODE NOLDS MOUNTAIN BOULEVARD VILLE, NC 28804 PROVIDER'S PLAN OF CORRECTION	s., t	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG			(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
F 280 SS=D	The resident has the incompetent or other incapacitated under participate in planning changes in care and A comprehensive care within 7 days after the comprehensive asses interdisciplinary tear physician, a register for the resident, and disciplines as determined to the extent post the resident, the resident, the resident, the resident of the resident of the resident of the resident. This REQUIREMENT by: Based on record refacility failed to reast interventions and resident of a resident of the resident of a resident of the resident of	right, unless adjudged rivise found to be the laws of the State, to a grare and treatment or a treatment. The plan must be developed the completion of the essment; prepared by an anity of the resident's needs, reacticable, the participation of aident's family or the resident's; and periodically reviewed and of qualified persons after. The plan must be developed the completion of the essment; prepared by an anity of the resident's needs, reacticable, the participation of aident's family or the resident's; and periodically reviewed and of qualified persons after. The plan of the resident staff interviews the essess the effectiveness of eview the plan of care to meet dent who was admitted with that was not locked and at of other residents rooms, maged through their personal quids on their bed for 1 of 1 or behavior and emotional 155).	F	280	1) 2) 3)	Resident # 155 no longer resident the facility. The Social Services Director, Dof Clinical Services and/or Supereviewed care plans of resident behaviors for affective resident specific behaviors 8/17/2016-8/24/2016. The Regional Director of Clinical Services in serviced the Direct Social Services on providing psychosocial services to meet residents wellbeing and how to follow up with residents with behavior's and update care play reflect specific interventions for residents with behaviors on 08/23/2016. The Director of Control Services and/or Nursing Superwill perform Quality Improvem Monitoring of residents with behaviors care plan's for residents psychosocial needs to times a week for twelve weeks substantial compliance is obtathen quarterly thereafter for one year.	pirector ervisor et's with it al or of the or those Clinical visor nent ent ent wo s until ined	

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OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 345447 B WNG 07/29/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 25 REYNOLDS MOUNTAIN BOULEVARD EMERALD RIDGE REHAB AND CARE CENTER ASHEVILLE, NC 28804 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION CX51 (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 280 Continued From page 34 F 280 4) The Executive Director introduced the Resident #155 was admitted to the facility on plan of correction to the Quality 07/12/16 with diagnoses which included blood Assurance Performance Improvement clots of the deep veins of left lower extremity, Committee on 8/22/2016. The results muscle weakness, lack of coordination, low back pain and Alzheimer's disease. A review of the of this audit will be reported to the admission Minimum Data Set (MDS) dated Quality Assurance Performance 07/19/16 indicated Resident #155 was severely Improvement Committee members impaired in cognition for daily decision making. A review of the behavior section of the MDS monthly for three months then revealed Resident #155 had physical behaviors quarterly thereafter for a year. directed toward others which occurred 1-3 days, Quality Assurance Performance verbal behaviors directed toward others which occurred 1-3 days and rejection of care which Improvement Committee members occurred 1-3 days. The MDS also indicated consist of but not limited to the Resident #155 required extensive assistance with Executive Director, Director of Clinical dressing, toileting, hygiene and transfers but Services, Unit Manager, Staff limited assistance with locomotion on the unit. Development, Activities, Medical A review of documents from a previous facility Director, Social Services, with a facsimile (fax) stamp dated 07/12/16 at Maintenance Director, Dietary 8:50 AM contained notes by a Social Worker (SW) which indicated Resident #155 had poor Manager and Minimum Data Set safety awareness and did not understand to call 8/25/16 Coordinator. for assistance. The notes further revealed Resident #155 was considered to be an elopement risk due to wandering and had exit seeking behaviors and in the evenings had increased behaviors of wandering and resisted care. The notes indicated Resident #155 lived on a secured Alzheimer's unit for a more structured and secure environment A review of an Admission Care Plan dated 07/12/16 indicated directions as follows: A care plan problem titled Behavioral Symptoms was circled and the goal was Resident #155 would have fewer episodes of and was left · incomplete. The approaches were checked with a check mark next to each as follows: redirect

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
						c
		345447	B. WING	B. WING		07/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	
EMERALD RIDGE REHAB AND CARE CENTER		RE CENTER		25 R	REYNOLDS MOUNTAIN BOULEVARD	
LINETONES	TRIBUE REFINO AND OF			ASH	HEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 280	Continued From page	. 35		280		
	resident as needed, a		113	200		(90)
	resident as needed, a					78.1
		d relaxed, remove from		7). 2).		1871
	public area if behavior					l.
	Contraction and the contraction of the contraction	l activities. There were no				9
1/2	notes related to any s			il		4
	interventions for staff		1	1		i
						1
		sion Data Collection form				i i
	which included the nu	상하다 시민(1) 다 이 100 Te S. 이 제 (4) 지난 (1) 12 (3
		/12/16 at 3:30 PM revealed		10		
		soriented to person, place				1
		The form also revealed	*	201		E.C.
		risk for elopement and had which included wandering,		11		
	resisted care and had		*:			i
	resisted care and nad	poor concentration.				i
	A review of a Care Are	ea Assessment (CAA)	E:			i
		by the SW dated 07/25/16				1
		nptoms triggered due to		Į.		į
		dering and the presence of				į
	at least 1 behavioral s	ymptom and a psychiatric		1		1
		ndicated. A question as to				İ
		mptoms and functional				1
		ssed in the care plan was		11		!
		er a section to describe the		i		
		or need on the resident plan decisions indicated the		į		
		eed to care plans at this	0			
	time.	eed to care plans at this				1
	MUDAL					086 .15
	During an interview or	07/29/16 at 7:16 AM				į
		esident #155 rummaged				
	through other resident	's things. She stated they				1
,		I to provide diversional		1		2
		ard to redirect. She stated				
	she did not recall any			8		Ê
		dent #155 and she had not		1		į.
	reassessed the effecti	veness of care plan				0.00

STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345447	B WING_		C 07/29/2016
	ROVICER OR SUPPLIER RIDGE REHAB AND CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE COMPLETION
F 280	Continued From page	÷ 36	F 2	280	er stem
	interventions.		1		18
,	Nurse #6 stated reside a notebook at the nur referred to them as not care plans were initial admitted to the facility supposed to come up care plan to provide in the resident. She state were expected to play on the residents care supposed to be updated.	seded. She further stated ted when a resident was and nursing staff were with interventions on the atterventions that best suited ted she was aware nurses a role in making changes plans and care plans were ted as needed however she t #155's care plan. She are plan to determine			
	Nurse #1 she stated fi behaviors and wande rooms and rummaged She explained resider a notebook at the nur	n 07/29/16 at 9:21 AM with Resident #155 had red into other resident I in their personal things. It's care plans were kept in se's station but was not sure care plan indicated for	1		
	interventions related to redirect him but he re-direct. She stated	o his behaviors other than was very difficult to she had not reassessed the			
		dent #155's care plan and ner specific Interventions rs.			
	Nurse #4 stated Residuand there was no way	n 07/29/16 at 9:25 AM dent #155 was confused to re-direct him because it ive. She stated the only		THE REST LIBERTY OF THE STATE O	
		recalled was to provide		3	;

CENTERS FOR WEDICARL &	MEDICAID SERVICES			OMB NO. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED
	0.000			С
	345447	B. WING		07/29/2016
NAME OF PROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
EMERALD RIDGE REHAB AND CA	ARE CENTER	25 R	EYNOLDS MOUNTAIN BOULEVARD	
EMERGED NIDGE RELIAD AND GO	THE VEHICLE	ASH	EVILLE, NC 28804	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
4		:		l l
F 280 Continued From page	e 37	F 280		\$
diversional activities	to distract him but that only	49		
worked temporarily.	She further stated she did	162		ä
	care plan for Resident #155			180
	sessed the interventions on			
his care plan.				i i
	07/00/40 -10:57 441 11:-	2		350
	n 07/29/16 at 8:57 AM the			0
	mpleted the CAA worksheet ad not received any formal	i		1
	CAA summaries or CAA			İ
	made a mistake when she	(40)		1
	ehaviors in one section but	i		
	care plan behaviors in			
	further stated she had not			М
provided any input on	the Admission Care Plan	1 040		1
for Resident #155's b		1		
		- 1		*
During an interview o	n 07/29/16 at 4:00 PM MDS			30
	he was responsible for			
	She stated the Admission	;		4
	also referred to as an	1		969
	placed in a resident's			19
	mission and nurses were			
	em and revise them as for the behavior care plan,	ř.		
	d to document interventions			
A POPEL OF PRODUCT PRODUCT AND A PART OF PRODUCT PRODU	nt and if they were not	1		
	ipposed to reassess and			
	She explained after the care			
plan was initiated the	y should be updated so staff			- F
would know what spe	cific interventions were	(C)		•
needed for the reside	nt. She stated the	S S		ji ~
	was initiated for Resident			1
#155 with the standar		1		
	ot been revised to include	n di		
interventions specific	to his behaviors.			Si .
	ATION (18 S. 18 S.			
	n 07/29/16 at 5:44 PM the			
Director of Clinical Se	rvices stated it was her			Fin

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345447	B. WNG	B. WNG			C 29/2016
NAME OF PROVIDER OR SUPPLIER EMERALD RIDGE REHAB AND CARE CENTER			25 REY	FADDRESS, CITY, STATE, ZIP CODE NOLDS MOUNTAIN BOULEVARD VILLE, NC 28804		20/20/0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	expected to see speci updated for Resident 483.25(h) FREE OF A HAZARDS/SUPERVIS The facility must ensu environment remains as is possible; and ea adequate supervision prevent accidents.	sident care plans inther stated she would have ific interventions listed and #155's behaviors. ACCIDENT SION/DEVICES ire that the resident as free of accident hazards	F 323		Resident #155 no longer resides the facility. Resident #121 was assessed by physician on7/28/2016. With no orders noted. Resident #28 was interviewed b Social Services Director on 7/28/to determine any concerns or psychosocial needs. No issues identified. Resident #99 side rail was tighte	the o new y the /2016	
	interviews the facility of environment for reside wandered in and out of touched them, rumma items and spilled liquid residents sampled for status (Resident #155 to ensure the side rail secured (Resident #95 dycem (a non-skid ma seat cushion in a reclin #78) for safety to preversidents sampled for The findings included: a. Resident #155 was 07/12/16 with diagnose	of other residents rooms, ged through their personal ds on their bed for 3 of 3 behavioral and emotional, #121 and #28) and failed on 1 resident's bed was 8) and failed to ensure terial) was placed on the ner for 1 resident (Resident ent accidents for 3 of 3 accidents.			on 7/25/2016 by the Maintenan Director. Resident #78 had the dycem discontinued by the interdisciplir team on 7/29/2016 and care plan updated. Side rails on current residents we checked for being secure on 7/26/2016 by the Maintenance Director. Current residents utilizing dycem for fall prevention were reviewed, and care plans and clin monitoring tool were updated.	nary n was ere	

OLIVIERO I OK WEDIONIKE & WEL	JIO/ IID OLITATOLO			ONID 110. 0000 0001
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A.O	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
				С
	345447	B. WNG _		07/29/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E
EMERALD RIDGE REHAB AND CARE	CENTER		25 REYNOLDS MOUNTAIN BOULEVAR	D
EMERALD RIDGE RETIAD AND GARE	CENTER		ASHEVILLE, NC 28804	
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION
F 323 Continued From page 39 muscle weakness, lack of pain and Alzheimer's dise admission Minimum Data 07/19/16 indicated Reside impaired in cognition for creview of a section in the revealed Resident #155 h directed toward others who verbal behaviors directed occurred 1-3 days and rejoccurred 1-3 days. The Markeident #155 required edressing, toileting, hygien limited assistance with local A review of documents frowith a facsimile (fax) stames:50 AM contained notes (SW) which indicated Resisafety awareness and did for assistance. The notes Resident #155 was considered a secured Alzheimer's unitant secure environment. A review of an Admission 07/12/16 with a problem sindicated a goal that Resifewer episodes of and the finished. The approaches check mark next to each a resident as needed, always a seeding behavior and the finished. The approaches check mark next to each a resident as needed, always a seeding a seed a seed a seed and the finished. The approaches check mark next to each a resident as needed, always a seed and the finished. The approaches check mark next to each a resident as needed, always and the seed and the finished. The approaches check mark next to each a resident as needed, always and the finished. The approaches check mark next to each a resident as needed, always and the finished. The approaches check mark next to each a resident as needed, always and the finished.	ease. A review of the Set (MDS) dated ent #155 was severely daily decision making. A MDS for behaviors had physical behaviors hich occurred 1-3 days, toward others which ection of care which MDS also indicated extensive assistance with e and transfers but comotion on the unit. In a previous facility he dated 07/12/16 at by a Social Worker sident #155 had poor not understand to call further revealed dered to be an endering and had exit the evenings had andering and resisted andering and resisted of the extension of the extensio	F 32	Interdisciplinary team of residents using dycem management to determ use. Residents with fall weekly in falls meeting appropriate fall interve interdisciplinary team of residents with fall inter 8/9/2016-8/24/2016. The Services Director performs for any psych for their wellbeing, and for other residents with 8/17/2016-8/24/2016. 3) The Maintenance Direct serviced by the Execution maintaining the side raims 8/19/2016. The Region Clinical Services in serviced by the Execution maintaining the side raims 8/19/2016. The Region Clinical Services in service of Social Service providing psychosocial meet the residents well how to follow up with repeating the side of the residents with behavior and update of reflect specific intervental residents with behavior 8/23/2016. Licensed Nu	for fall nine continued s are reviewed for ntions. The observed ventions he Social rmed Quality ng of current osocial needs any concerns behaviors ctor was in ve Director on al Director of iced the es on services to being and esidents with care plans to tions for those s On

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 20 10	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			700,20	_		С	
		345447	B. WNG	B. WNG			29/2016
NAME OF P	ROVIDER OR SUPPLIER			100081	TREET ADDRESS, CITY, STATE, ZIP CODE		
EMERALD RIDGE REHAB AND CARE CENTER			Utara	5 REYNOLDS MOUNTAIN BOULEVARD SHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	encourage diversional A review of an Admiss which included the nursessessment dated 07. Resident #155 was di and time at all times. was at risk for elopem symptoms which includere and had poor conference and had poor conference and had poor conference and had poor conference and had poor conference and had poor conference and had poor conference and had poor conference and had poor conference and had poor conference and had poor conference and had poor conference and had poor conference and had poor conference and had poor conference and co	I activities. Sion Data Collection form prising admission /12/16 at 3:30 PM revealed soriented to person, place. The form also revealed he ment and had behavioral ided wandering, resisted incentration. Inote dated 07/12/16 at 9:00 urse #1 indicated Resident frequently from other it was difficult to talk to edeclined to change out of clothes. Inote dated 07/13/16 during if M shift documented by esident #155 was observed ident's room and was Is note by a Nurse 13/16 indicated Resident iented to person only and amount of redirection. The Resident #155 had been sidents' rooms. Inote dated 07/14/16 at 6:00 urse #4 revealed Resident ghout the facility and in and rooms and had tried to go notes further revealed a	F	323	replacing items when not found. Maintenance Director will perfore Quality Improvement Monitoring resident 's with side rails for being secure three times a week for eign weeks, two times a week for four weeks until substantial compliant obtained and then quarterly thereafter for one year. The Soci Services Director will monitor residents with behavior's for residents with behavior's for residents with behavior's for residents with behavior's for residents with behavior's for residents with behavior's for residents with behavior's for residents with behavior's for residents with behavior's for residents with behavior's for residents with behavior's for residents week for four weeks, two times a week for four weeks and one time week for four weeks and/or until substantial compliance is obtained and then quarterly thereafter for year. The Director of Clinical Servand/or Nursing Supervisor will do Quality Improvement Monitoring fall interventions in place five time week for four weeks, three times week for four weeks and two times week for four weeks until substantial compliance is obtained then quarterly thereafter for one year.	m of gght ce is al dent dent dent des a a as a as a	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/15/2016 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING _ C 345447 B. WING 07/29/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 25 REYNOLDS MOUNTAIN BOULEVARD EMERALD RIDGE REHAB AND CARE CENTER ASHEVILLE, NC 28804 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 323 Continued From page 41 4) The Executive Director introduced the F 323 PM documented by Nurse #4 revealed Resident plan of correction to the Quality #155 was confused and was easily agitated. The Assurance Performance Improvement notes further revealed Resident #155 was difficult Committee on 8/22/2016. The results to redirect and became angry with staff and family and wandered in and out of other resident rooms. of this audit will be reported to the Quality Assurance Performance A review of a nurse's note dated 07/16/16 during Improvement Committee members the 7:00 AM to 7:00 PM shift revealed Resident #155 needed constant re-directing and cueing the monthly for three months then entire shift. The note further revealed Resident quarterly thereafter for a year. #155 wandered in and out of the other resident Quality Assurance Performance rooms. Improvement Committee members A review of a nurse's note dated 07/18/16 at 7:00 consist of but not limited to the PM documented by Nurse #1 revealed Resident Executive Director, Director of Clinical #155 wandered into resident rooms and in the Services, Unit Manager, Staff hall Development, Activities, Medical A review of a nurse's note dated 07/18/16 at 8:00 Director, Social Services, PM documented by Nurse #1 revealed Resident Maintenance Director, Dietary #155 had been redirected twice from other resident rooms. Manager and Minimum Data Set 8/25/16 Coordinator. A review of nurse's notes dated 07/19/16 at 11:35 AM documented by Nurse #7 revealed Resident #155 wandered into resident rooms and went through his roommate's personal things. The note indicated he would be moved to the locked dementia unit after lunch. During an interview on 07/27/16 at 4:16 PM Nurse #8 explained Resident #155 was difficult to redirect. During an interview on 07/29/16 at 8:57 AM the SW explained when Resident #155 was admitted to the facility she thought he would adjust and would get used to his surroundings and it wouldn't

have problems. She further stated if staff had

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		*****				С	
		345447	B. WNG			07/29/	2016
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
EMERALI	RIDGE REHAB AND CA	RE CENTER		25 RE	YNOLDS MOUNTAIN BOULEVARD		
			ASHE	VILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	42		323			
	A 155	andering behaviors and	. 1	023			
		esident's rooms and in their					
		ofter a day or so they should	*			1	
		Director of Clinical Services				1	
	and then to the SW.	on editor of emined edithees					
	WING WIGHT 10 WING DITT						
	During an interview or	07/29/16 at 9:21 AM		1			
19		esident #155 was difficult to					
	re-direct. She stated	Resident #155 couldn't					
	communicate and had	I combative behaviors.				**	
	She confirmed he wer					\$1	
		through their things and				1	
i	that bothered them.		1	92		i	
	6	07/20/40 -1 0.05 AM		- 5		į	
	During an interview or						
		ne had provided care to scribed him as confused	•			1	
		to re-direct him. She stated		1		9	
		nim but usually it was not				*	
		ed he rummaged around in				i	
		nd wandered in and out of					
		further explained she	87			i	
		versation with the SW about					
		ent #155 wandering in and				•	
	out of other resident's	room. She stated nursing		5		1	
		rovide activities to residents	E				
i		ehaviors but approximately				1	
	85 percent of the time	Resident #155 was difficult				•	
	to redirect.					E E	
		1/00/40 1 44 00 ALL 30 ALL	#1			2	
	Alternative and the second second second second second second second second second second second second second	7/29/16 at 11:39 AM with NA		1		;	
-	#3 she explained she Resident #155 before						
		She further explained he				- E	
		e resident's room and tried					
		the started yelling to get him					
		3 stated she had to get				Į.	
		er with getting him out of		f)			
		said the residents had told				4	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		STRUCTION	(X3) DATE SURVEY COMPLETED	
			SACSOT ACCOUNTS	S. (A-900).		С	
		345447	8. WNG			07/29/2016	
NAME OF P	ROVIDER OR SUPPLIER			= 0.00	TADDRESS, CITY, STATE, ZIP CODE		
EMERALD	RIDGE REHAB AND CA	RE CENTER			NOLDS MOUNTAIN BOULEVARD		
				ASHE	VILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 323	Continued From page	1.43		323		į.	
1 323	him he could come in		F	323.		į.	
		dent #155 wandered they		į			
		n a chair next to the nurse's	8	ŧ			
		ey could watch him but he				1	
	got up and walked wh	A					
	31, -p		1			1	
	During an interview or	n 07/29/16 at 2:42 PM with	3			1	
	the Director of Clinica	Services she explained	9			¥	
	she met with Residen	t #155 the day he was					
		. She further explained he				į.	
		other facility because his	1	i			
		erred. She stated the first		1			
		oncerns about Resident		2			
		from Nurse #1 on 07/18/16	1			*	
	when she reported sh	e had problems with him					
		ined she did not feel the ed with her about Resident	Ī				
	Videographic Viditor West CAN Gentley Control of Property Control	ause she was not made	1				
	aware until 07/18/16.	ause sile was not made				1	
	aware uniti 07710/10.			į		i i	
	b. Resident #121 who	was Resident #155's				ļ	
		ed to the facility on 05/25/16				•	
	with diagnoses which	·		1		į.	
		depression. A review of the					
	admission Minimum D	ata Set (MDS) indicated he		*			
	was cognitively intact	for daily decision making.		3		•	
				1		ì	
		note dated 07/12/16 at 9:00				i	
		urse #1 indicated Resident					
		Resident #155 had been				i	
	going through his thin	gs.	25				
	A review of a nurse's	note dated 07/13/16 at 5:45		*		ä	
		urse #1 indicated she was					
		55's room by a Nurse Aide					
	(NA) and Resident #1	5		*			
		of room between the bed					
		ated a small amount in the					
		e bed and was about to					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	101 101/2001/001/00	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		EST MATERIA	0. 200400000			С	
		345447	B. WING			07/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
ENEDALO	RIDGE REHAB AND CA	DE CENTED		25 R	EYNOLDS MOUNTAIN BOULEVARD		
EMERALL	KIDGE KEHAD AND CA	RE CENTER		ASF	EVILLE, NC 28804		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
E 202	0					3	
F 323	Continued From page		۲;	323		¥	
		121's head and face. The		8		140	
	notes further indicated			40		1	
		room by 2 staff and he		- 1		2007	
	urinated a large amou	int in the tollet.				-	
	A soulous of a puscala	note dated 07/17/16 at 1:00	j)	100		(6)	
		urse #2 indicated Resident		1		.M	
		ssive and semi-combative		100		i	
		07/15/16 with Resident				1	
	#121.	OTT OF TO WITH TRESIDENT					
	W. C. I.					1	
	A review of a nurse's	note dated 07/18/16 at 9:00				É	
		urse #1 revealed Resident					
		esident #121's bed while		- 1		•	
		ut of the room and had	1	i.		!	
	spilled drinks that wer	e on bedside table all over		i		1	
		rther revealed Resident				1	
	#121's bed linens wer	e all tangled and Resident	±0.	i		•	
	#155 had been drinking	ng Resident #121's left over	ž.	11		i	
:	ice tea. The note indi	cated Resident #155 was	i				
	redirected back to his	bed with the assistance of		- K		10	
	2 staff assist but he de	eclined to get ready for bed.					
		note dated 07/18/16 at		i			
		d by Nurse #1 revealed					
		directed from Resident	ii.	- 10		•	
		m and put in to bed but then	1				
	A STATE OF THE PARTY AND ADDRESS OF THE PARTY OF THE PART	arranged Resident #121's	65	10			
	bed covers.					10 10	
	A	1 d-1-d 07H0H0 -144.05	Ē.	E			
		otes dated 07/19/16 at 11:35	#	41			
		urse #7 revealed Resident		i			
		esident #121's personal		1		į	
	things.			i			
	During an Interview or	n 07/26/16 at 8:51 AM with				*	
		firmed he had been struck					
		y Resident #155. He stated		10			
		f the way of being struck).	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345447	B WING			07/29/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET	TADDRESS, CITY, STATE, ZIP CODE		
EMEDALI	DIDGE OF U.D. AND CA	DE CENTED		25 REY	NOLDS MOUNTAIN BOULEVARD		
EMERALI	O RIDGE REHAB AND CA	RECENTER		ASHE	VILLE, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(×5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 323	Continued From page	45	F :	323		9	
	to a second way to the second of the	ade contact with his right		Ų.		ý.	
		stated if he had not tried to					
		of Resident #155's strike, he					
		a harder strike. He further					
	stated he immediately						
	incident but could not	recall the name of the				П	
	nurse. He explained h	e had not been able to get					
	any rest or sleep whe	n Resident #155 wandered					
	around the room. He	stated he thought				9	
		I days after the incident the		4		i	
		sident #155 out of the room				*	
	but he thought the fac	[- BAN (- BAN) [- BAN (- BAN) - BAN (-	1	1		,	
		out of his room sooner				*	
		elt safe with Resident #155	1	-			
		he room and getting into his	ī			a .	
	personal belongings.						
	Davids a fall of the fall					i	
	그 경영 경영 경영 경우 기계 시작 시작 시작 중앙 경영 경영 시작 시작 시작 시작 시작 시작 시작 시작 시작 시작 시작 시작 시작	terview on 07/27/16 at 12:45 e was informed by Resident					
	#121 on 07/17/16 that	(40)				ĵ.	
		nd combative during the		ij		ā	
	• • •	nd had struck him. He	12	1		*	
	explained Resident #1			*		38	
	Resident #155 had m					i	
		ried to divert away from					
		urse #2 stated Resident		å		^*	
		injury from the strike and	8			1	
	S	ident #155 had become		×		9	
	aggressive and had b	een rummaging around in					
	the room. Nurse #2 st	ated the Social Worker		i		i	
,		was part of Administration		į			
		was informed on 07/17/16		1		II A	
		as not getting along with				**************************************	
		not remember if he had				1	
		sident #155 had struck him				**	
,		? further stated he was				Ü	
	informed by the SW th						
	roommate situation w						
	07/18/16 when the Ad	ministrator and Director of					

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ISTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		345447	B. WING		•	07/29/2016	
NAME OF PRO	VIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
EMEDAIDE	RIDGE REHAB AND CA	DE CENTER		25 RE	YNOLDS MOUNTAIN BOULEVARD		
LINENACON	IDOL KLING AND CA	INC CENTER		ASHE	VILLE, NC 28804		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
ĺ			3	1			
F 323 C	Continued From page	46	F	323			
. N	lursing (DON) were t	back in the facility. Nurse #2					
! s	tated he should have	informed the Director of					
N	lursing and the Admi	nistrator that Resident #155			*		
⁻ h	ad struck Resident #	121.				120	
			*				
		n 07/29/16 at 7:16 AM		Ī			
		esident #155 rummaged		40		3.90	
		t's things and went into		<i>r</i> o		į.	
		t. She stated staff talked				1	
		tried to distract him but at				i	
		rummaged through other		ij			
	in a significant person person a conservation and the significant	exhibited behaviors. She		ř.		33 5. 4 .	
		not assess Resident #155		1			
2 74 172		she thought that had				į.	
	lready been done an					į	
		cian about behaviors		- 1			
; D	ecause sne thought t	that had already been done.				13	
		07/00/10 01 0:57 441 15-	+	ŀ			
23	아이지는 경투를 없는 것을 되어 하셨다면요?	1 07/29/16 at 8:57 AM the		123		1	
		nt to Resident #155's room he was admitted because					
	MARKET AND BURNEY STREET, AND STREET	e had wandered some.					
		document Resident #155's				1	
120	기사회 '무슨데'라고싶으라면서 '가입하다'라!	nd she didn't hear any other				(a)	
		iors until it was reported to	ř				
		Resident #121 was upset				*	
		d wandered around the		1		1	
		and kept him awake. She		11.			
		scussed in the morning					
	neeting on 07/18/16 to						
		ocked dementia unit. She				i	
	xplained after the me					1	
		sident #155's roommate		190			
		was working on a room				1	
		e worked on the room				(f.)	
		e locked dementia unit was				15	
		19/16 a family agreed for a					
		o Resident #155 could be					
m	loved into the locked	dementia unit.					

OCITICIT	OT ON MEDIOTINE A	MEDIONIO CENTICEO				OMP NO. 0830-0381
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		ISTRUCTION	(X3) DATE SURVEY COMPLETED
						С
		345447	B. WNG			07/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
EMERALO	RIDGE REHAB AND CA	RE CENTER			YNOLDS MOUNTAIN BOULEVARD	
				ASHE	EVILLE, NC 28804	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 323	Continued From page	47	F	323		
	Nurse #1 explained o on Resident #121's b	n 07/29/16 at 9:21 AM ne night Resident #155 got ed and poured drinks on the dent #121 finally put a lock	a .			i
	on his closet door to be rummaging through h	eep Resident #155 from is things.	1			
	the Director of Clinical first time she heard at #155's behaviors was when she reported sh wandering and he had Resident #121 who who was a different with the diagnoses of rheumat side and type II diabe recent quarterly MDS moderately impaired it making.	as in bed. lived next door to Resident the facility on 05/02/15 with oid arthritis, paralysis of left les. A review of the most revealed she was n cognition for daily decision				
	11:50 PM documented Resident #155 wande by going through the b poked at Resident #20 wheelchair. The note #155was redirected b	note dated 07/12/16 at d by Nurse #1 indicated red into the room next door pathroom and picked and 3 who was still sitting up in a s revealed Resident ack to his room and was not bed and he was slightly	* * * * * * * * * * * * *			
G (2)	SW explained she wa	n 07/29/16 at 8:57 AM the s not aware Resident #155 ent #28's room next door				5 6

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	187 8	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345447	B. WNG		С
NAME OF B	SOMBER OF CHECKIER	040447	10.71110	CLOSSI ADODEON OLDV STATE 20 GO	07/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 25 REYNOLDS MOUNTAIN BOULEVAR	
EMERALO	RIDGE REHAB AND CA	RE CENTER			ξυ.
				ASHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	VIEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE COMPLETION EAPPROPRIATE DATE
F 323	Continued From page	48		323	Ŷ
1 020			Γ.	323	¥
	Nurse #1 explained st	1 07/29/16 at 9:21 AM			
		rough the bathroom door		4	
		om next door. She stated a			
		r that Resident #155 was			
	pulling at her clothes			4	
	Nurse #1 further state	d she went to Resident		¥	u.
		sed her but did not see any			
		She stated she felt at the		© 69	;
		as looking for his wife and			
		8 had felt threatened she			
	would have yelled bed	ed to get staff's attention.			
	usually did it sile wall	ed to get stail's attention.		*	*
	During an interview or	07/29/16 at 2:42 PM with	22		
		Services she stated staff			Í
	had to keep their eyes	on Resident #155 and		ž	T.
	Nurse #1 had told her			* :	
		nt # 28's room but did not		Ī	1
		icated with her in a timely			
	manner about Resider			F	
÷	because she was not	made fully aware until		F	
	07/18/16.	dmitted to the facility on		*	-
	08/19/15 and readmitt	idmitted to the facility on			e
	diagnoses which inclu				
		eakness, hemiplegia left			
		ion, muscle wasting, and		İ	<u>*</u>
	debility.				
					,
	A quarterly Minimum (*
		sident #99 was cognitively			~
		fied Resident #99 required			
		with activities of daily living			i
		ers and bed mobility. The			
		Resident #99 was impaired er extremities and both			
	sides of her lower extr				
	JIGGS OF HOLLOWEL CALL	S.I.I.N.O.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	01075112045550	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345447	B. WING			C 07/29/2016
	ROVIDER OR SUPPLIER D RIDGE REHAB AND CA	RE CENTER		25 REY	T ADDRESS, CITY, STATE, ZIP CODE YNOLDS MOUNTAIN BOULEVARD VILLE, NC 28804	0112010
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 323	Continued From page	: 49	F:	323		
ž X	revealed Resident #99	ssessment dated 05/21/15 9 used bilateral ¼ side rails for safety and as an enabler dependence.		ž.		r 1
i i	dated 04/14/16 reveal and oriented, had left	ission data collection form led Resident #99 was alert sided weakness, and sistance with bed mobility				E E H
	07/28/16 revealed Red desire to have bilatera data form further reve	ly data collection form dated sident #99 expressed the al ¼ side rails. The quarterly saled bilateral ¼ side rails ety and as an enabler to pendence.	*			
5 35 m	the bilateral ¼ side rai were observed up. The to be loose, wobbled by	n on 07/25/16 at 12:09: PM ils on Resident #99's bed he right side rail was noted back and forth and was enough room to fit between		¥6		
3.7	During an observation right side rail remained observed.	n on 07/25/16 at 4:43 PM the d loose as previously	*			
1	PM with Nurse Aide (N with the care of Reside Resident #99 was able the side rail as an assi further stated the ¼ side tightened at least 3 tim NA #4 explained she had to to tighten this side rail	ducted on 07/25/16 at 4:45 NA) #4 who was familiar ent #99. NA #4 stated e to turn herself and used istive device to turn. NA #4 ide rail for this bed had been nes that she remembered, had completed a work order just last Thursday 07/21/16 man came and tightened it.	1			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER CLIA IDENTIFICATION NUMBER.	10 W 1000	TIPLE CON	ISTRUCTION	(X3) DATE SURVEY COMPLETED
				77. 22. 22.		С
		345447	B. WING			07/29/2016
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP COCE	0.110/2010
				25 RE	YNOLDS MOUNTAIN BOULEVARD	
EMERALD RIDGE REHAB AND CARE CENTER			ASHE	VILLE, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	W
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	•		•	i		ı
F 323	Continued From page	50	F	323		i i
				ļ		
	An interview was con-	ducted on 07/25/16 at 5:08		í		
		ator. He observed the side				•
	Francous - William Statement and Statement Statement	e rail should be tight and	2			
		enance man fix it right away.				
		her stated he now knows				1
	the rails for Resident			!		1
		side rails for other beds in				
		e kind. The Administrator				
	맞으로 하고 있다면 하는 사람들이 되어야 했다. 사람들은 사람들이 없는 사람들이 되었다.	aintenance supervisor esident #99's side rails		×		i
	actually had a loosen					
		e bed. The Administrator	ð			ì
		icility was replacing the side		į		i
		bed related to this loose	1	į		ì
		rator confirmed the side rail		1		i
	was loose and needed					
		confirmed it was expected	ž.			
		attached correctly to beds to				ř
	prevent accidents from		2			
				£		
	An interview was cond	ducted on 07/28/16 at 11:15		i		*
	AM with the Facility M	aintenance Supervisor		I		
		ed he tightened the side				
	rails on Resident #99'	s bed and he had a work		İ		
	order from 07/21/16 fo	or side rails to be tightened.				
	The FMS stated staff	will complete work orders		1		1
	for side rails and he fit	kes them right away. The		ŧ		
	FMS further revealed	he had tightened Resident	î	l		!
	#99's side rails withou	t a work order in the past a		•		
		he was out on the halls				
		him. The FMS confirmed		:		
		il was loose and needed				1
	repaired. The FMS fur			*		
		ails to be attached correctly		4		
	to beds to prevent acc	cidents from occurring.		÷		ř.
	An into allow was seen	fucted on 07/28/16 at 3:10		8		
		se #4 who was familiar with		ŕ		
	I MI HITCHAIGM MITH IANI	SO IT WILL WAS INTILLED WILL				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(1) (a) (b)	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345447	B. WING_	All the second s	C 07/29/2016
	ROVIDER OR SUPPLIER RIDGE REHAB AND CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804	1 01/23/10
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ULD BE COMPLETION
F 323	Continued From page	÷ 51	F3	23	
	was unaware they we further stated she was	#99. Nurse #4 stated she are loose on Monday and as aware that Resident #99's intenance to tighten them hast.	⊕		
	PM with the Director of	ducted on 07/28/16 at 3:35 of Nursing (DON). The DON d for all side rails to be			-
	attached correctly to b	peds to prevent accidents ON stated he was unaware		:	
	12/05/12 and readmitted diagnoses which include		ř.	2 ×	
	1/5	alls, deformed fingers, disc disorder, orthostatic al episodes, and difficulty			ì
	intact. The MDS speci	Data Set (MDS) dated sident #78 was cognitively ified Resident #78 limited with activities of daily		*	
	living (ADL) including the MDS further speci	transfers and bed mobility. ified Resident #78 was not walker for ambulating.			į
9	on 05/19/16 and last u the potential risk for fa balance. The goals ind would be free of accide interventions included room free of clutter, no	in for Resident #78 initiated ipdated 07/08/16 identified ills related to impaired dicated for Resident #78 ent related injuries. The assist with transfers, keep onskid strips on the floor in em (a nonskid material			9 13 13

STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
74107 231 07 01	SKILEGIIGH	IDENTIFICATION NOWBER.	A. BUILD	NG		COME	PLETED
		10.1044/00/160	La Seminou				С
		345447	B. WNG			07/	/29/2016
NAME OF PRO	NAME OF PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
EMERALD RIDGE REHAB AND CARE CENTER				25 R	EYNOLDS MOUNTAIN BOULEVARD		
- Lineroxed IX	EIIILIVALD KIDGE KEINAD KIND CARE GENTER			ASH	EVILLE, NC 28804		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
				- 3	DEFICIENCY)		
			1				
F 323 C	ontinued From page	52	; F	323			•
U:	sed in chairs) to recli	iner seat cushion.		1			
		8's information kardex	1				
		d under safety for dycem to		禮			
be	e placed on recliner	chair cushion.					1
-	F - 3						!
		on 07/27/16 at 6:45 PM					!
		oted on floor in front of the		8			
		78. Further observation	1				1
	vealed no dycem wa 78's recliner chair.	as in place to Resident	7.5	3			
# /	ros recliner chair.			î			İ
. D	uring an absorbation	on 07/28/16 at 9:19 AM		1			
		oted on floor in front of the	-	8			
		78. Further observation		i			
		is in place to Resident					
	78's recliner chair.	is in place to resident		9			
				ŀ			
Ar	n interview was cond	lucted on 07/28/16 at 4:48		î.			
		Nurse #5. Nurse #5 stated		i.			
		falls investigations were					
re	viewed in the mornir	ng team meetings. Nurse	1	i			
#5	stated as a team in	terventions were					
im	plemented and ensu	ired the interventions and	8	50			
		for the residents as care	10			,	0
pla	anned.			20			
G2 8200			1				
		ucted on 07/28/16 at 4:55:		¥0 200			!
		IA) #4 who was familiar	Ť.	į			
		ent #78. NA #4 revealed					
		t and oriented but forgetful revealed Resident #78	0	Į.			
		revealed Resident #78 use her walker and had		8			
	zzy spells which we						
		or. NA #4 stated the strips	-			1	
		B's recliner were helpful to		di			
		lipping. NA #4 further		t		,	
		re that dycem was used but					
		wasn't any dycem in her					
5555							

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	88 20 L	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345447	B. WNG_			C 07/29/2016	
NAME OF PROVIDER OR SUPPLIER EMERALD RIDGE REHAB AND CARE CENTER		RE CENTER		STREET ADDRESS, CIT 25 REYNOLDS MOUN ASHEVILLE, NC 28	NTAIN BOULEVARD	ر.۲	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
F 371 SS=F	nonskid strips were not recliner for Resident # revealed no dycem with #78's recliner chair. An interview was come PM with the Director of stated Resident #78 vidizziness and falls religible pressures and vertigodycem was not on the further verified it was drawer. The DON states that the dycem should care planned in order related to sliding out of 483.35(i) FOOD PRO STORE/PREPARE/States The facility must - (1) Procure food from considered satisfactor authorities; and (2) Store, prepare, distunder sanitary conditions. This REQUIREMENT by: Based on observation facility failed to 1) discontinuations.	on 07/29/16 at 1:42 PM beted on floor in front of the 178. Further observation as in place to Resident ducted on 07/29/16 at 4:29 of Nursing (DON). The DON vas being monitored for ated to decreased blood . The DON verified the recliner chair cushion and found in Resident #78's red it was her expectation I be in place in the chair as to decrease the risk of falls of the chair. CURE, ERVE - SANITARY sources approved or y by Federal, State or local tribute and serve food ons is not met as evidenced as and staff interview the	F3	71 1) The Die expired 7/25/20 The Die thawed The Directo kitchen on The Dietary	etary Manager discarde I milkshakes on 7/25/20 or of Maintenance repa I door sweep in the 7/27/2016. I Manger discarded the Ininer of dry cereal on	ed 016. sired	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		345447	B. WING			07/	29/2016
	ROVIDER OR SUPPLIER RIDGE REHAB AND CA	RE CENTER		28	STREET ADDRESS, CITY, STATE, ZIP CODE 25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804	·, .*	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 371	ensure thawed milksh expiration 3) identify a exterior door sweep in store an open contain contamination. The findings included: 1. During the initial to 07/25/16 at 9:40 AM a of cottage cheese was shelving in the walk in on top of the containe "opened 06/28/16, use manufacturer expiration container of cottage container of cottage container of cottage container of cottage container of cottage container of cottage cheese varieties are was used in the lasage Director acknowledge stored past expiration handwritten on the conwas removed and appropriate cottage cheese had be remaining curds inside cottage cheese were provided to service director states the curds could have be from the last time the make lasagna. Reviewenus noted lasagna entree on 07/26/16. To discarded the outdate cottage cheese. 2. During the initial to	akes were used before and correct a damaged in the facility kitchen and 4) er of dry cereal to prevent as 5 pound plastic container is observed stored on a refrigerator. Handwritten in of cottage cheese was a by 08/28/16." A condate on the 5 pound heese was 07/17/16. The swas present at the time of tated the cottage cheese ina. The Food Service did the cottage cheese was and stated the dates intainer were wrong. The lid proximately 3/4 of the een used. Some of the een the 5 pound container of pink tinged. The Food did the pink tinge on some of the entertial of the facility preplanned was the planned lunch. The Food Service Director did 5 pound container of the facility kitchen on an open case of thawed 4 kes was observed on	F	371	2) The Dietary Manager performe observations of food storage ar for expired, undated open item thawed milkshakes on 8/17/20 The Dietary Manager has put a system in place to insure that e house shake that leaves the Die department has a 'used by' dat Dietary Manager has put a syst place to insure that there are n products that are undated or outdated per manufacture recommendations. This will be by dating every product with a by' sticker that will correspond date that is previous to the manufactures expiration date. Maintenance Director performe observations of doors with swe 8/19/2016. 3) The Dietary Manager and Dieta Staff were in serviced by the Die Dietary Manager on proper storand disposal of expired food pron 8/19/2016. The Maintenance Director was in serviced by the Executive Director on maintaining	eas s and 16. ach etary e. The em in c done use with a The ed eps on ry strict rage oducts e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	250025 00000000	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				С
	345447	B. WING		07/29/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
EMERALD RIDGE REHAB AND CA	RE CENTER	1	25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804	
			PROVIDER'S PLAN OF GORRECTIO	
PREFIX (EACH DEFICIENCY	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI)			IN (X5) D BE COMPLETION RIATE DATE
good for 14 days after vanilla milkshakes did on the individual carto thawed or the expiration the thawed vanilla milk the outside of the card 7/21, use by 8/3." On 07/26/16 at 8:35 AM a milkshake was observed pantry refrigerator. The strawberry milkshake is label noting the milkshake is label noting the milkshake thawed or the expiration 11:20 AM the Food Sekitchen staff dated the 4 ounce carton of milkstremoved from the free Director stated the box pulled and included a the pull date. The Food she had not thought at the "use by" date of the they left the facility kitch stored by staff in the number of the area surround or inside the facility observed in close proxinside the door. Daylig door in an approximate door sweep. The extendoor sweep appears the door sweep appea	illkshakes included a ting the milkshakes were thawed. The thawed not have anything written in to indicate when they had on date. The box housing shakes had handwritten on board container, "pulled 07/25/16 at 10:25 AM and thawed 4 ounce strawberry ed inside the nourishment e individual carton of included a manufacturer ake was good for 14 days here was nothing written on the individual carton of included a manufacturer ake was good for 14 days here was nothing written on the to indicate when it had for date. On 07/29/16 at rivice Director stated cardboard box housing the shakes when the box was zer. The Food Service is was dated when it was tuse by" date 14 days from described out the system to know the 4 ounce milkshakes once then if the milkshakes were	F 37	door sweeps on 8/19/2016. The Dietary Manager and/or Execute Director will perform Quality Improvement Monitoring of for storage areas for expired, undate open items and thawed milkshare five times a week for four week three times a week for four week until substantial compliance is obtained then quarterly thereat for one year. 4) The Executive Director and Di Manager introduced the plant correction to the Quality Assurance Improvement Committee on 8/22/2016. The of this audit will be reported to Quality Assurance Performance Improvement Committee members consisted in the quarterly thereafter for a year Performance Improvement Committee members consisted in the Executive Director of Clinical Services, U Manager, Staff Development, Activities, Medical Director, Sciences, Maintenance Director Dietary Manager and Minimum Set Coordinator.	tive od ted akes as, eks, ss fter etary of arance e results o the ce mbers en f. of but irector, nit ocial or,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVICER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULT A. BUILDIN		STRUCTION	(X3) DATE SURVEY COMPLETED
				1)	. с
	345447	B. WING _			07/29/2016
NAME OF PROVIDER OR SUPPLIER EMERALD RIDGE REHAB AND CA	RE CENTER		25 REY	FADDRESS, CITY, STATE, ZIP CODE NOLDS MOUNTAIN BOULEVARD VILLE, NC 28804	
PREFIX (EACH DEFICIENCY	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
something that should maintenance for repail Director stated there had of rodents or rodents to rodents or rodents to dry cereal was observed dry storage area of the cereal had been previous was observed in the opinside the box. The Formation present at the time of the food product should not her expectation was for placed inside a reseal opened. F 514 483.75(I)(1) RES RECORDS-COMPLET LE The facility must maint resident in accordance standards and practice accurately documented systematically organized. The clinical record must information to identify the resident's assessments services provided; the preadmission screening and progress notes. This REQUIREMENT by:	the door sweep and it was be reported to r. The Food Service and not been any evidence trapped in the kitchen area. OO PM a 15 ounce box of ed stored on shelving in the exitchen. The box of cously opened and cereal pen manufacturer bag and Service Director was the observation and stated of the stored open to air and or manufacturer bags to be able plastic bag once TE/ACCURATE/ACCESSIB ain clinical records on each exith accepted professional es that are complete; d; readily accessible; and ed. st contain sufficient the resident; a record of the s; the plan of care and	F 3	14 1)	to this citation. Resident #40 was not injured reto this citation. The Director of Nursing and/or Nursing Supervisor performed Comprovement Monitoring of medication administration recompletion of effectiveness of medications 8/9/2016-8/24/20.	Quality rds for 16.

	10 1 0111111111111111111111111111111111	THE SELECTION OF THE SE				ONID 140. 0930-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED
						, c
		345447	B. WING			07/29/2016
NAME OF P	ROVIDER OR SUPPLIER			20.000000000000000000000000000000000000	ET ADDRESS, CITY, STATE, ZIP CODE	
EMERAL	O RIDGE REHAB AND CA	RE CENTER		- CEEE	EYNOLDS MOUNTAIN BOULEVARD EVILLE, NC 28804	
(VALID	SUMMARY ST	NTEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
W/2 0045/760				18		
F 514	Continued From page		F	514	Clinical Services and/or Nursing	3
	facility failed to comple				Supervisor will perform Quality	!
		ectiveness or response of signatures for as needed			Improvement Monitoring of	
		9 of 12 months for 2 of 5		600	medication administration reco	ord
		unnecessary medications			being filled out completely thre	e.e
	(Resident #77 and #4	0).			times a week for four weeks, tw	
	The findings included;			72	times a week for four weeks an	d one
					times a week for four weeks un	
	Resident #77 was admitted to the facility on 11/01/13 with diagnoses which included heart				substantial compliance is obtain	ned
		n behavioral disturbances,			then quarterly thereafter.	
	anxiety, mood disorde	r, psychosis and		4)		d
		A review of the most recent			introduced the plan of correctio	in to
9:	quarterly Minimum Da	ta Set (MDS) dated sident #77 was severely			the Quality Assurance Performa	
,		or daily decision making		i	Improvement Committee on	nice .
3	and required extensive	e assistance with transfers,		į	8/22/2016. The results of this au	ıdit
		ut only required supervision			will be reported to the Quality	rait
	with locomotion.				Assurance Performance Improve	ament
3	A review of the monthl	y physician's orders dated			Committee members monthly for	
		0/15 indicated Ativan 0.5	Ĉ	2	three months then quarterly	
	milligrams (mg) by mo needed (PRN) for anxi				thereafter for a year Quality	at .
15.	necaea (i riri) ioi anxi	cty state.			Assurance Performance	
10		tion administration record		10	Improvement Committee memb	0.00
		through 09/30/15 revealed	10		consist of but not limited to the	ers
0	the following:	tivan 0.5 mg was given by	i.	8	consist of but not minted to the	
1		gitation but there was no	des.		Executive Director, Director of Cli	nical
17.		cumented and there was		40	Services, Unit Manager, Staff	
	no nurse's signature.	tivon 0.6 ma was alvon by			Development, Activities, Medical	į
		tivan 0.5 mg was given by gitation and anxiety but		W.	Director, Social Services,	
		response documented.	×.		Maintenance Director, Dietary	
		tivan 0.5 mg was given by	80		Manager and Minimum Data Set	1 2
		gitation but there was no cumented and there was			Coordinator.	8/25/16
100	tooning of teachoring (in	Daniel House and High Had				500 7

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED
w		345447	B. WNG		C 07/29/2016	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	0112312010
EMEDALO	EMERAL O DIDGE DELIAR AND GARE CENTED			25 RE	YNOLDS MOUNTAIN BOULEVARD	
EMERALL	EMERALD RIDGE REHAB AND CARE CENTER			ASHE	EVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 514	Continued From page	58	F	514		
	no nurse's signature.					1
		Ativan 0.5 mg was given by		i		•
		igitation but there was no		6		
3	results or response do no nurse's signature.	ocumented and there was				1
	no norse s signature.					1
i	A review of the month	ly physician's orders dated	10.1	i		
:		0/15 indicated Ativan 0.5				
		hours PRN for anxiety and	34			
	agitation.			1		
	A review of the MAR of	dated 11/01/15 through				
	11/30/15 revealed the					
		Ativan 0.5 mg was given by	Ŋ.	2		
		gitation but there was no	2			
	no nurse's signature.	ocumented and there was				ű
	no nuise s signature.					¥
	A review of the month	ly physician's orders dated				İ
	12/01/15 through 12/3	1/15 indicated Ativan 0.5		**		
	75 355	hours PRN for anxiety and				
	agitation.			1		
	A review of the MAR of	lated 12/01/15 through		2		
	12/31/15 revealed the	이 얼마나 되었다.				Î
7		itivan 0.5 mg was given by		1		
		gitation but there was no	ž.	İ		E.
		cumented and there was		iii		*
	no nurse's signature.					İ
	A review of the monthl	y physician's orders dated		i.		ł
	01/01/16 through 01/31/16 indicated Ativan 0.5			1		Į.
		nours PRN anxiety and				
į.	agitation.			. 60		1
	A review of the MAR d	ated 01/01/16 through				1/
	01/31/16 revealed the	- International Control of Cont		1		1
a ·	01/02/16 at 3:25 PM A	tivan 0.5 mg was given by		1/2/2		
, x	mouth for kicking door	s and increased anxiety but	A			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTR	RUCTION	(X3) DATE SURVEY COMPLETED
		0.00.13	6 4444	D MANG		С
		345447	B WNG.		07/29/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET AD	DDRESS, CITY, STATE, ZIP CODE	
EMERALI	RIDGE REHAB AND CA	RE CENTER			LDS MOUNTAIN BOULEVARD	
THE CAUSE OF THE COLUMN	A STATE OF THE STA			ASHEVIL	LE, NC 28804	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 514	Continued From page	59	, F	514		u .
		r response documented.		1		4
		Ativan 0.5 mg was given by				
,		there was no results or				'
	response documented					
		Ativan 0.5 mg was given by				W.
	no results or response	estlessness but there was				1
	no results or response	documented.				
	A review of the monthl	y physician's orders dated				
	02/01/16 through 02/0	8/16 indicated Ativan 0.5				
		hours PRN anxiety and		1		
	agitation and was disc	ontinued on 02/08/16.				*
Į	A review of the MAR d	ated 02/05/16 at 2:00 PM				
3		g was given by mouth for		i		Ø*
		t there was no results or	ė	i i		
	response documented					
1	A review of a physician	n's order dated 02/08/16		i		
		g by mouth daily as needed				:
	for anxiety.	g of mount daily as needed	ř			į
						İ
1	A review of the MAR d	ated 02/14/16 at 4:30 PM				
3		was given by mouth for		i		i i
		there was no results or		27		
i	response documented					1
1	A review of monthly ph	veician's orders dated				
		0/16 indicated Ativan 1.0		8		
1	mg by mouth daily PRI					
i	E 1	€				5
	A review of the MAR d	ated 04/01/16 through		15		
		04/09/16 Ativan 1.0 mg was		1		Į.
given for increased agitation but no route was					2	
		response was documented				8
	and there was no nurs	e signature.				48
	A review of the monthly	y physician's orders dated		580		500
		1/16 indicated Ativan 1.0		i.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		345447	B. WNG			C 07/29/2016
NAME OF P	ROVIDER OR SUPPLIER	L		STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 0112312010
ENCOVIT	S DIDOT DELIAD AND OA	***		100000000000000000000000000000000000000	YNOLDS MOUNTAIN BOULEVARD	
EMERALL	RIDGE REHAB AND CA	RE CENTER		000000000	EVILLE, NC 28804	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	378131000.00	PROVIDER'S PLAN OF CORRECTION	244
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 514	Continued From page	: 60	F	! 514		
	mg PO daily PRN anx		₹. nr			i
	The second secon					
		dated 05/01/16 through 05/17/16 at 3:30 PM Ativan				
		mouth for increased anxiety				
		Its or response and no	*			,
	nurse signature docum	nented.		į.		
1	A raview of the month	ly physician's orders dated				
	06/01/16 through 06/3	30/16 indicated Ativan 1.0				Į.
	mg by mouth daily PR		*			F.
9	// J - / // // // // // // // // // // // //					2
19		dated 06/01/16 through 06/28/16 at 4:30 PM Ativan				
		n for increased agitation				į į
		vas no results or response		-		i i
	and no nurse signature	(*)	11	0		
			D.	16		i
	During an interview on		÷)			1
	Nurse #8 stated nurse					
		of the MAR when PRN				i
		n and the documentation e and hour given, the route,	¥0	D		
	the reason for the med					
	response of the medic					
	signature.					
	20 au 20 au		Ses			E
	During an interview on					1
	Nurse #3 explained nu			1		
		a resident requested PRN				
	medications and nurse	es were supposed to eness or the results of the				
	medication. She further					
		be documented on the				
to.	back of the MAR.					
	During an integrious an	07/20/46 at 0.04 AM				
	During an interview on Nurse #6 stated nurses					
		after a PRN medication				,
	reassess the resident	atter or retrifficological				ļ

STATEMENT OF CEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	345447	B. WING		С
NAME OF PROMOCO OR CURRUED	343447	B. WING		07/29/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
EMERALD RIDGE REHAB AND CA	RE CENTER		25 REYNOLDS MOUNTAIN BOULEVARD	
			ASHEVILLE, NC 28804	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLETION
j				
F 514 Continued From page	61	F.	514	3
was given to see if it v	vas effective or not.	φ.	•	
	cation was not effective		E	
they were expected to	write a note in the	ž),		1
physician's communic	ation book so the		140	
medication would be r			9	2/4
	ctitioner. She explained if a			58 89
	given for anxiety they were			*
expected to document	en an entitief de transfer de de construction en enten en enten en entende entende en entende en entende en en		2	
administration and the		1		
medication after it had			ii	ž
medication was not eff			1	*
expected to notify the	physician. She stated I to document effectiveness			8. %
	ations on the back of the			9
		1		18 19
MAR and they were supposed to document their signature.				
oignatore.		i i		% %
During an interview on	07/29/16 at 1:59 PM the			3
Director of Clinical Ser		3	•	
expectation for nurses	to document on the back		•	
of the MAR when PRN	medications were given		:	
and it should include date, the time of day, route			Ī	
	ren, name of medication,			
	ess of the medication and			1
the nurse's signature.		×	•	
	a problem with nurses not			1 1
15	ness of medications or their			1
	t Coordinator would review		*	1
documentation and lea				
complete their docume	intation.	91		
2 Resident #40 was a	idmitted to the facility on			i
	es which included dementia			*
with behavioral disturb				
deficits, anxiety and Al		p 8		
	ent quarterly Minimum Data	E.	is	1
	1/16 revealed Resident #40		P	,
was severely impaired			15	
decision making and re	equired extensive	1		

	io i o i i i i i i i i i i i i i i i i	I DELIVIOLO				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER.CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		A. OUICE		Administrativa Mandala da Sant		
345447		B. WING			C 07/29/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREI	ET ADDRESS, CITY, STATE, ZIP CODE	1 0172072010
EMEDALO	NODGE BELLAR AND GA	DE ACUTED		25 RE	YNOLDS MOUNTAIN BOULEVARD	
EMERALL	RIDGE REHAB AND CA	RECENTER		ASH	EVILLE, NC 28804	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD B	E COMPLETION
TAG	. REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAC	. !	CROSS-REFERENCED TO THE APPROPRI	
					DEFICIENCY)	
E 644	^ ·· · · -	×2.0		i		
F 514	Continued From page		F	514		
	assistance with activit	ies of daily living.		1		1
				ĺ		£
		nysician's orders dated		ı		
	07/01/16 through 07/3			- 1		
		(mg) by mouth twice a day				ſ.
	as needed for agitation	n and anxiety				
	A raviou of a Madicali	on Administration Decemb		10		
		on Administration Record	1			
8	the following:	through 07/31/16 revealed		4		
	~	tivan 0.5 mg was given by		1		.00
8		gitation. There was no cumented and there was	50	1		
	no nurse's signature.	comented and there was				
		itivan 0.5 mg was given by				
		gitation. There was no	E			
	results or response do	- North Control of the Control of th	į			
		tivan 0.5 mg was given by		į		
	mouth for increased agitation. There was no results or response documented and there was					30 190
no nurse's signature.		comented and there was		1		
I	no naise a signature.			i		
	During an interview on	07/28/16 at 4:07 PM		į		
	Nurse #8 stated nurse			- 1		
		of the MAR when PRN	*	*		
	medications were give	n and the documentation				
	should include the date	and hour given, the route,	9			
*	the reason for the med	ication, the results or	N.			i
	response of the medical	ation and the nurse's				
	signature.		9			
				i		ļ
	During an interview on			į		
80	Nurse #3 explained nu	100	6.8	i		i i
		resident requested PRN		1		
medications and nurses were supposed to			•		3 =	
		ness or the results of the		i		
medication. She further stated this						
	documentation should	be documented on the		1		5
	back of the MAR.			4		

CLITTLIN	OT ON WEDIONINE &	MEDIONIO GENVICES				JMB NO. 0938-03		
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUI A. BUILD			(X3) DATE SURVEY COMPLETED		
		345447	B. WING			, C 07/29/2016		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	017110110110		
				REYNOLDS MOUNTAIN BOULEVARD				
EMERALD	RIDGE REHAB AND CA	ARE CENTER		250-560	HEVILLE, NC 28804			
				1	121122,110 20004			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETICH COMPLETICH		
F 514	Continued From page	63	F	514				
	Contract to the contract of th	n 07/29/16 at 8:01 AM						
	Nurse #6 stated nurse	. H						
		after a PRN medication						
	was given to see if it v							
		cation was not effective						
,	they were expected to			- 66				
5	physician's communic		Ø.	170				
-	medication would be r	•				1		
		ctitioner. She explained if a given for anxiety they were		i		1		
	expected to document			-		E .		
	administration and the					2		
	medication after it had							
	medication was not eff	and the state of t						
	expected to notify the							
		to document effectiveness	9			!		
	V 57	ations on the back of the		9				
	MAR and they were su	ipposed to document their				İ		
	signature.					Į.		
-	During an interview on	07/29/16 at 1:59 PM the		1		in the second se		
	Director of Clinical Ser	vices stated it was her	7					
	expectation for nurses	to document on the back						
1	of the MAR when PRN	I medications were given						
4	and it should include the	ne date, time of day, route				4		
3	the medication was giv	en, name of medication,						
34	response or effectiven	ess of the medication and		2				
	the nurse's signature.	She explained she		£				
		a problem with nurses not		į		1		
		ness of medications or their		*				
		t Coordinator would review				11		
	documentation and lea			į		3		
	complete their docume	entation.						
	483.75(o)(1) QAA		F 5	520 1) Facility has QAPI committee in pl	ace :		
	COMMITTEE-MEMBE	RS/MEET			and implements plans for			
* 1	QUARTERLY/PLANS		2		improvement and monitors and			
					DITE STOTILOTIC STICE THOUSE STICE	1		

PRINTED: 08/15/2016 FORM APPROVED

CLIVICI	NO FOR WILDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345447	8. WNG				С
NAME OF C	PROVIDER OR SUPPLIER	343447	B. WING			07	7/29/2016
WANE OF F	-KOVIDEN OK SUFFLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
EMERAL	D RIDGE REHAB AND CA	RE CENTER		25528	EYNOLDS MOUNTAIN BOULEVARD		
				ASH	EVILLE, NC 28804		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
F 500		raying I	500	1			+
F 520	Continued From page	64	F S	520	revises as needed through the	QAPI	
	4.4.4		3		process.		i
		n a quality assessment and	a	2)	The RDCS re-educated the		1
	assurance committee	consisting of the director of			interdisciplinary team member	s on	9
	facility; and at least 3	ysician designated by the	8.		regulation F520 and the facility	's	
	facility's staff.	other members of the			policy and procedures for Qual		1
	radinty 5 stair.				Assurance Performance Improv	ement	1
	The quality assessme	nt and assurance			on 8/8/2016. The Minimum Da	ta Cot	
		ast quarterly to identify			Coordinator reviewed the last 3		1
	issues with respect to	which quality assessment			of CAA's of current residents to	o days	
	and assurance activities	es are necessary; and					*
develops and implements appropriate plans of		ents appropriate plans of			ensure that strengths and		
	action to correct identi	fied quality deficiencies.			weaknesses related to behavior	sor	
9					psychosocial status was address	sed	
	A State or the Secreta	ry may not require	5),	1	8/17/2016-8/24/2016		
	disclosure of the recor		1	, 3)	The Social Services Director was		
	except insorar as such	disclosure is related to the		3	serviced on completing accurate	9	
	compliance of such correquirements of this se	mmittee with the		1	CAA's related to resident behav	iors	
	requirements of this se	ection.			with identifying specific strengtl		
,	Good faith attempts by	the committee to identify	(iii		weakness's by the Regional Case		
†	and correct quality defi	ciencies will not be used as		1			
	a basis for sanctions.			į	Mix/MDS Coordinator on 8/22/2	2016.	
4					The Director of Clinical Services		
3					and/or the Minimum Data Set		
		is not met as evidenced			Registered Nurse will audit CAA'	s of	1
1	by:	**************************************			residents with behavior's based		
	Committee failed to ma	ssessment and Assurance		į			
		r these interventions that	5		the MDS schedule for accuracy t		1
i	the committee put into			ř	times a week for twelve weeks of	r	
;		recited deficiency which			until substantial compliance is		
	was originally cited in A			63 93	obtained then quarterly thereaft	er	
		nd subsequently recited on	6		for one year.		
	the current recertification	on survey. The deficiency	(1) (1)				
	was in the area of accuracy of assessment. The			4	The Regional Vice President of	× ×	
continued failure of the facility during two federal				Operations and/or RCDS will con	duct		
		a pattern of the facilities fective Quality Assurance		i	Quality Improvement monitoring	of	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ C 345447 B WING 07/29/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 25 REYNOLDS MOUNTAIN BOULEVARD EMERALD RIDGE REHAB AND CARE CENTER ASHEVILLE, NC 28804 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG F 520 Continued From page 66 F 520 process and they tried to audit the things they had failed at in the past but it was difficult to monitor and keep everything in compliance because there was so much to monitor.

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FORM APPROVED