**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

345447

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING ________________

B. WING ________________

**(X3) DATE SURVEY COMPLETED**

C 09/22/2016

**NAME OF PROVIDER OR SUPPLIER**

EMERALD RIDGE REHAB AND CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

25 REYNOLDS MOUNTAIN BOULEVARD

ASHEVILLE, NC  28804

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 000</td>
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<td>Initial Comments</td>
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No deficiencies were cited as a result of the complaint investigation. Event ID # NC00119746.

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

-Laboratory Director's or Provider/Supplier Representative's Signature-

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

Event ID: COF611

Facility ID: 923161

If continuation sheet Page 1 of 1