DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				F	ORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	;		OMPLETED
							С
		345048	B. WING				08/23/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ΜΟΠΝΤΑΙ	N RIDGE HEALTH AND F	REHAB			611 OLD US HIGHWAY 70 EAST		
					BLACK MOUNTAIN, NC 28711		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC	ION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI		COMPLETION DATE
TAG			TAG	1	DEFICIENCY)		
F 500	Notify of Changes (In			<b>F</b> 0			0/14/10
F 580		jury/Decline/Room, etc.)	F	58			9/14/18
SS=D	CFR(s): 483.10(g)(14	)(1)-(1V)(15)					
	§483.10(g)(14) Notific	nation of Changes					
	-	ediately inform the resident;					
		ent's physician; and notify,					
		her authority, the resident					
	representative(s) whe	•					
		ving the resident which					
		as the potential for requiring					
	physician intervention	· · · ·					
		ge in the resident's physical,					
	mental, or psychosoc						
		, mental, or psychosocial					
		eatening conditions or					
	clinical complications	-					
	(C) A need to alter tre	atment significantly (that is,					
	a need to discontinue	an existing form of					
		erse consequences, or to					
	commence a new for						
	(D) A decision to trans	3					
	resident from the facil	lity as specified in					
	§483.15(c)(1)(ii).						
		fication under paragraph (g)					
		the facility must ensure that					
		on specified in §483.15(c)(2)					
		ded upon request to the					
	physician.	also promptly notify the					
		lent representative, if any,					
	when there is-	ient representative, il dily,					
		or roommate assignment					
	as specified in §483.1	•					
		ent rights under Federal or					
		ns as specified in paragraph					
	(e)(10) of this section						
		ecord and periodically					
		nailing and email) and					
	phone number of the						
	representative(s).						
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE

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

TITLE

09/11/2018

PRINTED: 09/17/2018

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.

**Electronically Signed** 

-				FORM	APPROVED
DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	
	345048	B. WING			C 23/2018
ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
			611 OLD US HIGHWAY 70 EAST		
N RIDGE HEALTH AND F	REHAB		BLACK MOUNTAIN, NC 28711		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From page	2 1	F 58	30		
§483.10(g)(15) Admission to a compo that is a composite di §483.5) must disclose its physical configurat locations that compris part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record revi interviews the facility physician/Nurse Prace scheduled dialysis tre administering medica missed doses includir and 10 doses of insul reviewed for notification Findings included: Resident #296 was an 08/07/18 with diagnos stage renal disease, of amounts of sugar in the disease, and depended process used to clear Review of the entry M 08/07/18 revealed Resident #22 a central vein cathete connection between a	<ul> <li>bisite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations</li> <li>is not met as evidenced</li> <li>ew, staff, and physician failed to notify the titioner when a resident's to attent conflicted with tions resulting in multiple of 6 doses of an antiplatelet in for 1 of 1 resident on (Resident #296).</li> <li>dmitted to the facility on ses which included end diabetes mellitus (excessive he blood) with chronic renal ence on renal dialysis (a nse the blood of impurities).</li> <li>linimum Data Set dated to ute hospitalization.</li> <li>care plan dated 08/07/18 296 received dialysis through r. A left upper arm fistula (a an artery and vein used to to attact a set to the to attact to the to the to the to attact to the to the totact to totact to the totact to totact to the totact to the totact to the totact to totact to the totact totact to the totact to the totact to the totact to the totact to totact totact to totact to totact totac</li></ul>		The facility nurse practitioner for Ret #296 was notified on 8/22/18 by the Director of Nursing that two medicati were missed numerous times due to conflictions with the resident's out of facility dialysis schedule. The facility nurse practitioner and Director of Nu on 8/22/18 reviewed Resident #296 medication regimen and adjusted medication administration times to pr missed doses due to the Resident #2 being out of the facility at dialysis. The Director of Nursing on 8/22/18 conducted an audit to identify any oth residents that were receiving dialysis other treatments on a set schedule requiring the resident to be out of the facility for extended lengths of time. Director of Nursing identified one oth resident that is out of facility related to dialysis treatment. The identified res had not missed any doses and the medication regimen did not require a changes. Additionally, the Director of Nursing did extend the audit to include	racility ons rsing event 296 ner or The er o ident ny of	
connection between a	an artery and vein used to		Nursing did extend the audit to include	le	
	S FOR MEDICARE & S FOR MEDICARE & PF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER N RIDGE HEALTH AND F SUMMARY ST. (EACH DEFICIENCI REGULATORY OR I Continued From page §483.10(g)(15) Admission to a compo that is a composite di §483.5) must disclose its physical configural locations that compris part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record revi interviews the facility physician/Nurse Prac scheduled dialysis tre administering medica missed doses includir and 10 doses of insul reviewed for notificati Findings included: Resident #296 was at 08/07/18 with diagnos stage renal disease, o amounts of sugar in the disease, and dependent process used to clear Review of the entry M 08/07/18 revealed Resident #22 a central vein catheter connection between at the interim/baseline of identified Resident #22 a central vein catheter connection between at the stage renal disease of the facility after an ac	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345048         ROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 1         §483.10(g)(15)         Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).         This REQUIREMENT is not met as evidenced by:         Based on record review, staff, and physician interviews the facility failed to notify the physician/Nurse Practitioner when a resident's scheduled dialysis treatment conflicted with administering medications resulting in multiple missed doses including 6 doses of an antiplatelet and 10 doses of insulin for 1 of 1 resident reviewed for notification (Resident #296).	S FOR MEDICARE & MEDICAID SERVICES         PF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIF A. BUILDING         345048       B. WING	S FOR MEDICARE & MEDICAID SERVICES         PERFERENCIES       (X1) PROVIDERSUPPLIERCULA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         345048       BUILDING         SOMDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX         Continued From page 1       F 580         \$483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part. A facility that is a composite distinct part, and must specify the policies that apply to room changes between its different locations under \$483.15(C)(9).       F 580         Findings included:       The facility nurse practitioner for Rest #296 was notified on 8/22/18 by the policies including 6 doses of an antiplateit and 10 doses of insulin for 1 of 1 resident reviewed for notification (Resident #296).       The facility anter receiving diaysis conducted an adjusted medication regime and ad	MENT OF HEALTH AND HUMAN SERVICES       FORM         S FOR MEDICARE & MEDICALD SERVICES       OMB NC         or deficiencies       (x1) encourse plantacian       (x2) Multiple Construction       (x3) occurse         operation of the service o

Facility ID: 922973

If continuation sheet Page 2 of 21

		ND HUMAN SERVICES MEDICAID SERVICES				I	NTED: 09/17/2018 FORM APPROVEI B NO. 0938-039
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345048	B. WING				C 08/23/2018
NAME OF PI	ROVIDER OR SUPPLIER	-		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				61	1 OLD US HIGHWAY 70 EAST		
MOUNTAI	N RIDGE HEALTH AND	RENAD		В	LACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 580	Continued From pag	e 2	F 5	80			
			15		any missed medication administration	n	
	along with poor contr				any missed medication administratic within the prior 30 days. The 100%		
	The hospital dischard	ge summary dated 08/07/18			was completed 9/4/18.	auun	
		t #296 presented to the					
	•	07/31/18 with a blood sugar			The Director of Nursing began education	ation	
	level greater than 70	0 and left upper arm			on 8/23/18 to licensed nurses on fac	ility	
	-	medications upon discharge			expectation of physician notification		
		l fast acting insulin (a			missed administration of medication		
		control high blood sugar			Education was continued and compl		
		el (an antiplatelet medication			by the Staff Development Coordinate		
	which thins the blood	to prevent blood clots).			9/7/18. Any new hired nurses will b		
	A review of the physi	ician progress note dated			provided education during orientatio the facility expectation of physician	1 ON	
		esident #296's history of end			notification for missed administration	of	
	stage renal failure wi				medications.		
	-	2 diabetes mellitus. The					
		ed the high blood sugar			The Director of Nursing, and/or design	gnee	
	levels were controlle	d upon admission to the			inclusive of the Quality Assurance N	urse,	
	facility and the plan w	was to monitor and adjust			MDS Nurse, and Staff Development		
	insulin as needed.				Coordinator will review the Medication	on	
					Administration Records for those		
	Review of the active	physician orders included:			identified residents who are out of th	е	
	a clonidoard bioute	to give 1 tablet by mouth and			facility frequently related to dialysis		
		te give 1 tablet by mouth one distribution distributicada distributicada distributicada distributicada distri			treatment and/or other procedures requiring the resident to be out of the	2	
	was started on 08/08				facility frequently and for extended le		
					of time. The audits will occur 5 time		
	b. Inject 14 units of ir	nsulin aspart before meals			weekly for a period of 4 weeks, 2 tim		
	and inject insulin asp	-			weekly for a period of 4 weeks, 1 tim		
	perimeters before me	eals and at bedtime for			weekly for 4 weeks, biweekly for 4 w	eeks,	
		Iminister 12 units of insulin			and monthly for 3 months. The findi	•	
		blood sugar levels in 1 hour			will be reviewed weekly by the Direc		
		al Doctor for blood sugar			Nursing and any additional educatio	n or	
		n 450. The medication was			monitoring will be implemented as	- of	
	started on 08/07/18.				necessary dependent on the finding the audit.	5 01	
	-	st 2018 monthly medication					
	administration record				The Director of Nursing is responsib		
	documented Resider	nt #296 was out of the facility			implementing this Plan of Correction	and	

Facility ID: 922973

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	S FOR MEDICARE &					NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
		345048	B. WING		o	C 8/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				611 OLD US HIGHWAY 70 EAST		
MOUNTAI	N RIDGE HEALTH AND I	REHAB		BLACK MOUNTAIN, NC 28711		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 580	(Clopidogrel) schedul dates: 08/09 (Nurse # (Nurse #1), 08/16 (Nu and 08/21 (Nurse #1) Resident #296 was or receive insulin aspart AM. On 08/11 Nurse #296 was out of the f insulin aspart doses s 11:00 AM. On 08/14 J Resident #296 was or receive insulin aspart 08/16 and 08/18 Nurse #296 was out of the f insulin aspart schedul AM. On 08/21 Nurse #296 was out of the f insulin aspart schedul AM. On 08/21 Nurse #296 was out of the f insulin aspart injectio and 11:00 AM. The h on the days Resident was 434 on 08/21 at During an interview of Nurse #1 explained F dialysis treatments or not administered. Sho was scheduled at 8:00 for dialysis around 5: facility at approximate Resident #296 was s aspart at 7:30 AM be AM before lunch alon dose based on perim readings. Nurse #1 re	ntiplatelet medication led daily on the following #1), 08/11 (Nurse #3), 08/14 urse #4), 08/18 (Nurse #4), b. Nurse #1 documented ut of the facility and did not t injection on 08/09 at 7:30 #3 documented Resident acility and did not receive scheduled for 7:30 AM and Nurse #1 documented ut of the facility and did not t scheduled at 7:30 AM. On se #4 documented Resident acility and did not receive led at 7:30 AM and 11:00 #1 documented Resident acility and did not receive ns scheduled for 7:30 AM ighest blood sugar reading t #296 had missed insulin	F 58		vement he QAPI limited to, strator, Director, , Social tary Medical Pharmacy reviewed for on will aining uirements. thanged to d ain	

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CENTERS FOR MEDICARE & MEI					OMB NC	APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
	345048	B. WING _				C 23/2018
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
			6	11 OLD US HIGHWAY 70 EAST		
MOUNTAIN RIDGE HEALTH AND REH	IAB		В	BLACK MOUNTAIN, NC 28711		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580 Continued From page 4 on Tuesday, Thursday, a #296 would leave the fac 5:45 AM missing the breat didn't return to receive the causing the medication to some days. Nurse #1 rev lunch doses were missed dose would be at 4:00 PM resident missed schedule days she would inform th She indicated she could of medication administration days and could only revie working and wasn't aware missed several days/dose insulin aspart injections. During an interview on 08 FNP confirmed she wasn missed multiple doses of identified the antiplatelet important medication that administered and explain to a history of blood vess considered the fact an an was not administered as significant error and woul been informed when mult The FNP confirmed no ha explained the process us treatments included an at and the fact no concerns the dialysis center related central line catheter used treatments. The FNP review was used to treat Reside history of high blood suga have adjusted the insulin informed of the blood suga	cility at approximately akfast dose and at times he lunch dose of insulin o be missed twice on vealed if breakfast and d the next scheduled M. She explained when a ed medications for 2-3 he Medical Doctor/FNP. not review the n record for previous ew the day she was re Resident #296 had ses of the antiplatelet and 8/22/18 at 3:21 PM, the n't aware Resident #296 f medications. She medication as the most at should have been hed the reason was due sel occlusion. She ntiplatelet medication ordered to be a lid've have liked to have ltiple doses were missed. harm had occurred and sed during dialysis antiplatelet medication is had been identified by d to gaining access to the d to provide the vealed the insulin aspart ent #296's diabetes and iar readings. She would n dose if she had been	F	580			

Facility ID: 922973

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345048	B. WING				C 23/2018
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
MOUNTAI	N RIDGE HEALTH AND F	REHAB			1 OLD US HIGHWAY 70 EAST ACK MOUNTAIN, NC 28711		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580 F 584 SS=D	liked to have been inf of medications were r During an interview of Director of Nursing (D expectation when me administered, nurses Doctor/FNP. The DOI ask for a physician's of administration times t being missed. The DO the physician/FNP ha an order was provided administrations times medications to ensure days she received dia During an interview of 4:20 PM, the Adminis expectation nurses we Doctor/FNP when res conflicted with medicat causing multiple medi- administered. She ex- times would be adjust were not missed. Safe/Clean/Comfortat CFR(s): 483.10(i)(1)-(0 §483.10(i) Safe Envirn The resident has a rig comfortable and hom	irmed she would've have formed when multiple doses missed. In 08/23/18 at 9:57 AM, the DON) revealed it was her dications were not would contact the Medical N expected the nurses to order to change the o prevent medications from DN confirmed on 08/23/18, d been made aware of and d to change the for Resident #296 morning e they were received on the alysis treatments. In 08/22/18 at trator revealed it was her ould notify the Medical idents' dialysis schedule ation administration times ications not to be pected the administration ted to ensure medications ble/Homelike Environment (7) onment. ght to a safe, clean, elike environment, including	F 5				9/14/18
	but not limited to rece supports for daily livin The facility must prov §483.10(i)(1) A safe, o	ng safely.					

Facility ID: 922973

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345048	B. WING				C 23/2018
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MOUNTAI	N RIDGE HEALTH AND F	≀EHAB			11 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	use his or her persona possible. (i) This includes ensure receive care and serve physical layout of the independence and do (ii) The facility shall ex- the protection of the r or theft. §483.10(i)(2) Houseks services necessary to and comfortable inter §483.10(i)(3) Clean b in good condition; §483.10(i)(4) Private resident room, as spe §483.10(i)(5) Adequa levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observation facility failed to maintain	t, allowing the resident to al belongings to the extent ring that the resident can vices safely and that the facility maximizes resident bes not pose a safety risk. xercise reasonable care for esident's property from loss eeping and maintenance o maintain a sanitary, orderly, ior; ed and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); te and comfortable lighting table and safe temperature ly certified after October 1, temperature range of 71 to maintenance of comfortable is not met as evidenced ns and staff interviews, the ain cleanliness for 1 of 2 rs observed (Resident #31).	F	584	The wheelchair for resident #31 was identified to have visible soiling related failure of staff to adhere to facility procedure for routine equipment clean and monitoring for as needed cleaning The wheelchair for Resident #31,	ing	

Event ID: 3RS311

Facility ID: 922973

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TATEMENT C	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		3 NO. 0938-03 DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	, ,	G	· · ·	COMPLETED
						С
		345048	B. WING			08/23/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
MOUNTAI	N RIDGE HEALTH AND	REHAB		611 OLD US HIGHWAY 70 EAST		
				BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 584	Continued From pag	e 7	F 58	34		
		PM, Resident #31 was		inclusive of the armrest, wh	eels, spokes,	
		d with her wheelchair placed		and seat cushion was clear		
		wheelchair was observed		by the Director of Nursing.		
		the size of a walnut on the			<b>,</b> , , , , , , , , , , , , , , , , , ,	
	• •	t, crumbs in the seam of the		An audit of the cleanliness		
		od particles stuck on the side tween the left armrest and		wheelchairs, inclusive of the wheels, spokes, and seat c		
	the seat cushion.			began on 8/24/18 and was		
				8/28/18. The audit was cor		
	An additional observ	ation on 08/23/18 at 10:37		Quality Assurance nurse, D		
		te smudge was still on the		Nursing, and MDS nurse.	•	
	-	e resident was sitting in the		wheelchairs identified to be		
		shion and plate under the		required cleaning to mainta		
	spokes of the wheels	observed. At this time, the		comfortable and homelike e was thoroughly cleaned.	environment	
	-	erved with dust that was		was thoroughly cleaned.		
		iping making a little pile of		Certified Nurse Aides were	provided	
	dust.			education by the Staff Deve	•	
				Coordinator beginning 9/4/1		
		rsing Assistant (NA) #2 on		completing 9/7/18 on the fa		
		A revealed the night shift had		and expectation for monitor		
		that should be cleaned each d during the day, the NAs		maintaining resident wheeld other adaptive mobility devi		
		pe debris from the chairs.		comfortable, and homelike		
	F P			Director of Nursing and\or of		
		Director of Nursing (DON)		inclusive of the Staff Develo	opment Nurse,	
		AM revealed third shift staff		Quality Assurance Nurse, o		
		many wheelchairs that were		will audit five wheelchairs d	•	
		ned each night. The DON staffing had recently been		per week for four weeks, 5 times weekly for a period of		
		hat this task was done had		wheelchairs 1 time weekly 1		
	fallen through the cra			wheelchairs biweekly for 4		
	<b>U</b>			wheelchairs monthly for 3 n		
				ensure proper cleanliness.		
				will be reviewed weekly by		
				Administrator and any addit		
				education or monitoring will		
				implemented as necessary the findings of the audit.	dependent on	

Event ID: 3RS311

Facility ID: 922973

If continuation sheet Page 8 of 21

STATEMENT OF DEFICI AND PLAN OF CORREC	ENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X2) MULTIPLE CONSTRUCTION         IDENTIFICATION NUMBER:       A. BUILDING       (X2)         345048       B. WING       (X2)		(X3) DATE COMP	LETED			
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
F 641 Accura SS=D CFR(s \$483.2 The as resided This R by: Based facility Data S	sessment mus nt's status. EQUIREMENT I on record revi failed to accura iet (MDS) for 2 nedication asse			584	The Director of Nursing is responsible frimplementing this Plan of Correction and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The QAPI committee consists of, but not limited to the Director of Nursing, Administrator, Quality Assurance nurse, MDS Director Staff Development Coordinator, Social Worker, Activities Director, Dietary Manger, Maintenance Director, Medical Records, Medical Director, and Pharma Consultant. The audits will be reviewed monthly and recommendations for changes to the plan of correction will occur if the facility is not maintaining compliance with regulatory requirement The plan of correction can be changed include additional education and monitoring to obtain and maintain substantial compliance. Date of Compliance: September 14, 2000 The assessments for Resident #59 and Resident #54 were identified to have coding inaccuracies for injections due to the failure of the MDS department to thoroughly review the medication and accurately in the medication and maintain substantion records and accurately is solved.	d , , , hcy d ts. to 018	9/14/18

Event ID: 3RS311

Facility ID: 922973

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE S	. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	` '		COMPL	
					C	;
		345048	B. WING		08/2	3/2018
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTAI	N RIDGE HEALTH AND	REHAB		611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711		
	STIMWADA S.	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETIC DATE
F 641	Continued From pag	e 9	F 64	1		
		admitted to the facility on	-	document the total number of in	jections in	
		oses including but not limited		section N0300. The completed		
	to diabetes.			assessments for Resident #59 a	-	
	Dovious of the sure (	du Minimum Data Oct (MDO)		Resident #54 were corrected an	-	
		rly Minimum Data Set (MDS) aled Resident #54 revealed 1		modified to represent the accura number of injections the residen		
		lookback and the 1 injection		received during the assessment		
	received was identifi	-		period. The modified assessme		
				submitted on 8/22/18.		
		ation Administration Record				
		revealed Resident #54 had		The Director of Nursing and Reg		
	-	n injections during the 7-day		Director of Clinical Reimbursem		
	lookback period.			conducted an audit of all assess completed within the prior 30 da		
	During an interview of	on 08/22/18 at 1:30 PM, the		ensure the accurate documenta	-	
	•	viewed and verified the MDS		injections administered in correl		
	had been coded inco	prrectly and stated her		the medication administration re		
	expectations were for	or the MDS coding to be		Audit was completed on 9/4/18.		
	correct.			assessment identified with a cor		
	During an interview			and modification completed and		
	During an interview of Director of Nursing (	on 08/23/18 at 1:36 PM, the		submitted.		
		or the MDS to be coded		Education was provided by the l	Regional	
	correctly.			Director of Clinical Reimbursem	-	
				8/28/18 to the MDS Coordinator	and MDS	
		admitted to the facility		Assistant on the accurate comp		
	-	oses which included diabetes		Section N0300. The Director of	•	
	mellitus and cerebra	I infarction.		will audit 100% of completed MI		
	A review of the most	current admission Minimum		assessments for four weeks, 50 completed MDS assessments for		
		ed 07/14/18 under section N		weeks, 25% of completed MDS		
		indicated Resident #59		assessments for four weeks, an	d 10% of	
		during the 7-day look back		completed assessments monthl		
		ment. Section N also		months. The MDS assessment		
	indicated 5 doses of			reviewed for accuracy of coding		
	medication used to t	nin the blood) was		section N0300 in comparison th		
	administered.			Medication Administration Reco findings will be reviewed weekly		
	A review of the July			Administrator and any additiona		

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 09/17/201 RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345048	B. WING		0	C 8/23/2018
NAME OF P	ROVIDER OR SUPPLIER	•	- <b>i</b>	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTAL				611 OLD US HIGHWAY 70 EAST		
WOUNTAI	N RIDGE HEALTH AND F	<b>CERAD</b>		BLACK MOUNTAIN, NC 28711		
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 641 F 677 SS=D	documented injection 07/10, 07/11, 07/12, 0 included an anticoagu thin the blood) and a (infectious lung disea revealed an anticoag days during the look l assessment from 07/ 07/13, and 07/14. During an interview c 1:40 PM, the MDS Co recorded 5 injections look back period, but MAR confirmed 5 ant administered equaling overlooked the TB inj anticoagulant medica she documented 5 do confirmed 6 doses we missed 1 dose. She e would be done to refil injections received we anticoagulant doses a During an interview c 10:05 AM, the Directo expectations were for coded. ADL Care Provided fo CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily	d (MAR) revealed 6 ons were administered. The is received were from 07/09, 07/13, and 07/14 and ulant (a medication used to test for tuberculosis se) (TB) injection. The MAR ulant was administered for 6 back period of the 09, 07/10, 07/11, 07/12, onducted on 08/22/18 at pordinator/RN explained she were given during the 7-day after she reviewed the July icoagulant and 1 TB was g 6 injections. She ection. After reviewing the tions administered in July, pses were administered. She ere administered and she explained a modification ect the correct number of ere 6 and correct number of administered were 6. onducted on 08/23/18 at or of Nursing revealed her r the MDS to be correctly or Dependent Residents	F 64	<ul> <li>education or monitoring will be implemented as necessary depert the findings of the audit.</li> <li>The Director of Nursing is responsimplementing this Plan of Correct reporting the findings to the Qualit Assurance Performance Improve (QAPI) Committee monthly. The committee consists of, but not limit the Director of Nursing, Administr Quality Assurance nurse, MDS D Staff Development Coordinator, S Worker, Activities Director, Dietar Manger, Maintenance Director, M Records, Medical Director, and P Consultant. The audits will be remonthly and recommendations for changes to the plan of correction occur if the facility is not maintain compliance with regulatory require The plan of correction can be char include additional education and monitoring to obtain and maintain substantial compliance.</li> <li>Date of Compliance: September</li> </ul>	sible for ion and ty ment QAPI ited to, rator, irector, Social y ledical harmacy viewed vr will ing ements. inged to	9/14/18

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		MEDICAID SERVICES				<u>IO. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	LE CONSTRUCTION	· · /	TE SURVEY MPLETED
	CONNECTION	DENTIFICATION NOMBER.	A. BUILDING			
		245049	B. WING			С
		345048	B. WING		0	8/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTAI	N RIDGE HEALTH AND	REHAB		611 OLD US HIGHWAY 70 EAST		
				BLACK MOUNTAIN, NC 28711		
(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 CORR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 677	Continued From page	e 11	F 67	7		
		Γ is not met as evidenced				
	Based on observation interviews the facility 1 of 5 sampled reside staff for assistance w (ADLs) (Resident #32			The fingernails for Resident #32 identified to be at a length in wh trimming would be appropriate of failure to initiate trimming during assigned shower schedule as a nurse aides not having a clear	ich lue to staff the result of	
	The finding included: Resident #32 was admitted to the facility on 04/25/18 with diagnoses which included Alzheimer's' disease, dementia, diabetes mellitus (DM), and depression.		understanding of the facility exp an acceptable length for fingern the resident does not indicate a preference. The fingernails for I #32 were trimmed by the Licens Practical Nurse on 8/22/18.	ails when Resident		
	07/01/18 indicated th moderately impaired assistance for most c and personal hygiene	Data Set (MDS) dated e Resident's cognition was and required extensive staff of his ADLs included bathing e. The MDS indicated history of refusal of care.		An audit of all residents' nails wa conducted by the Director of Nu Quality Assurance Nurse on 8/2 Nails were trimmed if necessary nursing staff on 8/22/18.	rsing and 2/18.	
	#32 with ADLs self-ca related to generalize specified the Resider level of function in AD home. Interventions i staff regarding bathin checked nail length a bath day and as nece	-		Education was provided to Certi Aides by the Staff Development beginning on 9/4/18 and comple 9/7/18 on the facility procedure a expectation for maintaining the p length of dependent resident find Certified Nurse Aides were prov education to ensure nails are cle trimmed on shower days and as Director of Nursing and\or desig inclusive of the Staff Development	Nurse ting on and proper gernails. ided eaned and needed. nee ent Nurse	
	Resident #32's finger millimeter (MM) beyo all 5 fingernails on ea	3/20/18 at 11:02 AM revealed mails extended 3-4 and her fingertips. However, ach hand were observed stances under each nail.		and Quality Assurance Nurse, w five residents daily five times pe four weeks, 5 residents 2 times a period of 4 weeks, 5 residents weekly for 4 weeks, 5 residents for 4 weeks, and 5 residents mo	r week for weekly for 1 time biweekly	

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STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		STRUCTION	(X3) D	NO. 0938-039 ATE SURVEY OMPLETED
			A. BUILDING				
	345048		B. WING			С	
		545046			ADDRESS, CITY, STATE, ZIP CODE		08/23/2018
NAME OF P	ME OF PROVIDER OR SUPPLIER						
MOUNTAI	REHAB			D US HIGHWAY 70 EAST K MOUNTAIN, NC 28711			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 677	Continued From pag	e 12	E 67	7			
F 6//	PM and 08/22/18 at of fingernails remained substances were observation PM, Resident #32 sta when his fingernails like to have his fingernails like to have his fingernails in an interview condurer PM, Nurse Aide (NA) shower to Resident # residents' skin condition during the shower. H #32's fingernails were beyond the fingertips residents' fingernails inch (about 6.35 MM him. That was why h #32's fingernails con added Resident #32 fingernails had to be An observation was of 08/22/18 at 03:40 PM fingernails that were beyond the fingertips immediately. She atto of communication be her carelessness wh Resident #32. She a have a history of refu	03:10 PM revealed the untrimmed. No brownish served under each nail. ucted on 08/22/18 at 03:10 ated he was unable to recall were last trimmed. He would rnails trimmed in a timely e did not have to request for vould check and trim his d. ucted on 08/22/18 at 03:27 ) #3 stated he had provided #32 on 08/21/18. He checked tions included fingernail le was aware of Resident e extended about 3-4 MM s. However, he stated any that were less than ¼ of an ) would not be a concern to e did not report Resident idition to the nurse. He was a diabetic and his trimmed by a nurse. conducted with Nurse #2 on <i>I</i> . She stated Resident #32's about 3-4 MM extended a needed to be trimmed ributed the incident as a lack etween nurses and NAs and en she provided care for dded Resident #32 did not	F 67	find Adu edu imp the The imp rep Ass (Q/ cor the Qu Sta Wo Ma Rev Col mo cha occ cor The incl mo sub	dings will be reviewed weekly by ministrator and any additional ucation or monitoring will be blemented as necessary depend findings of the audit. e Director of Nursing is responsi- blementing this Plan of Correction borting the findings to the Quality surance Performance Improvem API) Committee monthly. The Q mmittee consists of, but not limite e Director of Nursing, Administrat ality Assurance nurse, MDS Director, Mer Cordinator, So prker, Activities Director, Dietary inger, Maintenance Director, Mer cords, Medical Director, and Pha nsultant. The audits will be revie onthly and recommendations for anges to the plan of correction w cur if the facility is not maintainin mpliance with regulatory requirer e plan of correction can be chan- lude additional education and initoring to obtain and maintain ostantial compliance. te of Compliance: September 14	ent on ble for n and ent API ed to, or, ector, cial dical armacy ewed ill g nents. ged to	
	Nursing (DON) on 08	nducted with the Director of 3/23/18 at 11:04 AM. The ot a facility policy to defer					

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED C		
		345048	B. WING			0	8/23/2018
NAME OF PI	ME OF PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTAIN RIDGE HEALTH AND REHAB				61	1 OLD US HIGHWAY 70 EAST		
				В	LACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIOI DATE
F 677	Continued From page	e 13	F	677			
		are until they were ¼ of an					
		d fingertips. It was her					
	· ·	e resident to receive proper					
F 700	nail care as ordered i	-	_				0/4 4/4 0
F 760 SS=D	CFR(s): 483.45(f)(2)	f Significant Med Errors	F	760			9/14/18
33-D	011((3). +00.+0(1)(2)						
	The facility must ensu	ure that its-					
		nts are free of any significant					
	medication errors.						
	by:	is not met as evidenced					
	-	iew, staff, resident, and			The facility nurse practitioner for Reside	ent	
		the facility failed to prevent a			#296 was notified on 8/22/18 by the faci		
	significant medicatior				Director of Nursing that one significant		
		f an antiplatelet medication			medication was missed for six doses due	е	
	#296).	viewed for dialysis (Resident			to conflictions with the resident's out of facility dialysis schedule. The facility		
	#230).				nurse practitioner and Director of Nursin	na	
	Findings included:				on 8/22/18 reviewed Resident #296	.5	
					medication regimen and adjusted		
		tal history and physical			medication administration times to preve		
	report dated 07/31/18	3 for Resident #296 re performed on 06/22/18.			missed doses due to the Resident #296 being out of the facility at dialysis.		
		o widen a central vein			being out of the facility at Uldiysis.		
	-	(a plastic or metal tube			The Director of Nursing on 8/22/18		
	inserted into a blocke	d passageway to keep open			conducted an audit to identify any other		
	and restore blood flow	w) had been successful.			residents that were receiving dialysis or		
	The hospital discharg	ne instructions dated			other treatments on a set schedule requiring the resident to be out of the		
	The hospital discharg 08/07/18 included a li	ist of medications Resident			facility for extended lengths of time. The	e	
		to receive. Clopidogrel (an			Director of Nursing identified one other	-	
	antiplatelet medicatio	n which thins the blood to			resident that is out of facility related to		
		vas to be administered every			dialysis treatment. The identified reside	nt	
	24 hours.				had not missed any doses and the		
	Resident #296 was a	dmitted to the facility on			medication regimen did not require any changes. Additionally, the Director of		
	08/07/18 with diagnos	•			onanges. Additionally, the Director of		

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						NO. 0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	OATE SURVEY	
			A. BUILDING			с	
		345048	B. WING			08/23/2018	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			00/20/2010	
MOLINTAIN RIDGE HEALTH AND REHAB				611 OLD US HIGHWAY 70 EAST			
MOUNTAI	N RIDGE HEALTH AND	REHAB		BLACK MOUNTAIN, NC 28711			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 760	Continued From pag	ie 14	F 76	50			
	· · · · · · · · · · · · · · · · ·	diabetes mellitus with		100% of current census to ev	aluate for		
		e, and dependence on renal		any missed medication admin			
		ised to cleanse the blood).		within the prior 30 days. The			
				was completed 9/4/18.			
	Review of the entry	Minimum Data Set dated					
	08/07/18 revealed R	esident #296 was admitted to		The Director of Nursing bega			
	the facility after an a	cute hospitalization.		on 8/23/18 to licensed nurses			
				expectation of physician notif			
		care plan dated 08/07/18		missed administration of med			
		296 received dialysis through		Education was continued and			
		er. A left upper arm fistula (a		by the Staff Development Co			
		an artery and vein used to ment) was also identified.		9/7/18. Any new hired nurse provided education during or			
		iment) was also identilied.		the facility expectation of phy			
				notification for missed admini			
	Review of the facility	physician orders of 08/07/18		medications.			
		aled 75 milligrams of					
	clopidogrel was to be	e given one time a day and		The Director of Nursing, and/	or designee		
		thinner. The medication was		inclusive of the Quality Assur			
	scheduled to start or	า 08/08/18.		MDS Nurse, and Staff Develo	•		
				Coordinator will review the M			
		ist 2018 monthly medication		Administration Records for th			
	administration record			identified residents who are o			
		nt #296 was out of the facility		facility frequently related to d	-		
		medications scheduled for le anticoagulant medication		treatment and/or other proce requiring the resident to be o			
		as scheduled daily on the		facility frequently and for exte			
		9 (Nurse #1), 08/11 (Nurse		of time. The audits will occur	•		
		l), 08/16 (Nurse #4), 08/18		weekly for a period of 4 week			
	(Nurse#4), and 08/2			weekly for a period of 4 week			
				weekly for 4 weeks, biweekly	for 4 weeks,		
		conducted on 08/22/18 at		and monthly for 3 months. T	•		
		296 explained dialysis		will be reviewed weekly by th			
		eduled three times a week		Nursing and any additional e			
		ne facility and the dialysis		monitoring will be implemented			
		d using a notebook to		necessary dependent on the the audit.	maings of		
	and after each treatr	erns and outcomes prior to					
		vein catheter in the right		The Director of Nursing is res			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /		· · · ·	OMPLETED
				С		
		345048	B. WING			08/23/2018
NAME OF P	IAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTAIN RIDGE HEALTH AND REHAB				611 OLD US HIGHWAY 70 EAST		
MOUNTAIN RIDGE HEALTH AND REHAB				BLACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 760	Continued From page	e 15	F 76			
F 760	upper chest was acco and denied any proble receiving dialysis. Re- feeling weak after dia was normal, and den During an interview of 2:26 PM, Nurse #1, v explained she docum out of the facility on of t administered. Nurse was scheduled at 8:0 would leave the facilit for dialysis treatment missed. Nurse #1 sta physician that Reside her 8:00 AM medicat went to dialysis. During an interview of Family Nurse Practiti wasn ' t aware Resid multiple doses of me- facility at dialysis treat antiplatelet medication medication that shou and explained the reat occlusion and a stend considered the fact at was not administered significant error and v been informed when The FNP confirmed r explained the process treatments included at and the fact no conce	essed to provide treatments ems had occurred with esident #296 explained alysis treatments, and that ied not feeling well. conducted on 08/22/18 at who worked 7AM to 7 PM mented Resident #296 was lays the blood thinner wasn ' e #1 revealed the medication 0 AM and Resident #296 ty at approximately 5:45 AM causing medications to be sted she had not notified the ent #296 had not received ions on the mornings she on 08/22/18 at 3:21 PM, the oner (FNP) revealed she ent #296 had missed dications when out of the stments. She identified the on as the most important Id have been administered ason was due to a history of ting procedure. She n antiplatelet medication	F 76	<ul> <li>implementing this Plan of Correct reporting the findings to the Quat Assurance Performance Improvide (QAPI) Committee monthly. The committee consists of, but not lift the Director of Nursing, Adminis Quality Assurance nurse, MDS I Staff Development Coordinator, Worker, Activities Director, Dieta Manger, Maintenance Director, I Records, Medical Director, and I Consultant. The audits will be remonthly and recommendations for changes to the plan of correction occur if the facility is not maintai compliance with regulatory requered The plan of correction can be changed additional education and monitoring to obtain and maintai substantial compliance.</li> <li>Date of Compliance: September</li> </ul>	lity ement e QAPI mited to, trator, Director, Social ary Medical Pharmacy eviewed for n will ning irements. hanged to I in	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345048 B. WING						C 23/2018
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         611 OLD US HIGHWAY 70 EAST							
MOUNTAI	N RIDGE HEALTH AND F	REHAB			11 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711		
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page	9 16	F	760			
F 880 SS=D	Director of Nursing (D expectation when me administered, nurses Doctor/FNP. The DOI ask for a physician's administration times t being missed. The DO the physician/FNP ha an order was provided administrations times medications to ensure days she received dia During an interview cd 4:20 PM, the Adminis expectation nurses we Doctor/FNP when res conflicted with medica causing multiple medi administered. She exp times would be adjust were not missed. Infection Prevention & CFR(s): 483.80(a)(1)( §483.80 Infection Cor The facility must estal infection prevention a designed to provide a comfortable environm development and trar diseases and infection p program.	would contact the Medical N expected the nurses to order to change the o prevent medications from DN confirmed on 08/23/18, d been made aware of and d to change the for Resident #296 morning e they were received on the alysis treatments. Onducted on 08/22/18 at trator revealed it was her ould notify the Medical idents ' dialysis schedule ation administration times ications not to be pected the administration ted to ensure medications & Control (2)(4)(e)(f) htrol blish and maintain an nd control program safe, sanitary and pent and to help prevent the asmission of communicable	F	880			9/14/18
	administration times t being missed. The DO the physician/FNP ha an order was provided administrations times medications to ensure days she received dia During an interview cd 4:20 PM, the Adminis expectation nurses w Doctor/FNP when res conflicted with medica causing multiple medi administered. She ext times would be adjust were not missed. Infection Prevention & CFR(s): 483.80(a)(1)( §483.80 Infection Corr The facility must estat infection prevention a designed to provide a comfortable environm development and trar diseases and infection §483.80(a) Infection p program.	o prevent medications from DN confirmed on 08/23/18, d been made aware of and d to change the for Resident #296 morning e they were received on the alysis treatments. Donducted on 08/22/18 at trator revealed it was her ould notify the Medical idents ' dialysis schedule ation administration times ications not to be pected the administration ted to ensure medications & Control (2)(4)(e)(f) htrol blish and maintain an nd control program safe, sanitary and uent and to help prevent the asmission of communicable ns.	F	880			9/14/ <sup>-</sup>

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
345048			B. WING				23/2018
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTA	N RIDGE HEALTH AND F	REHAB			611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	a minimum, the follow §483.80(a)(1) A syster reporting, investigatin and communicable di staff, volunteers, visite providing services un arrangement based un conducted according accepted national star §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility (ii) When and to whor communicable disease reported; (iii) Standard and trart to be followed to prev (iv)When and how iso resident; including bu (A) The type and durate depending upon the in involved, and (B) A requirement that least restrictive possil circumstances. (v) The circumstances must prohibit employed disease or infected secontact with residents contact with residents	IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other in possible incidents of se or infections should be resmission-based precautions ent spread of infections; blation should be used for a t not limited to: att not limited to: att not limited to: att not spread of or organism t the isolation should be the oble for the resident under the s under which the facility ees with a communicable cin lesions from direct s or their food, if direct	F	880			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 09/17/201 1 APPROVE 0. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345048	B. WING				_ 23/2018
NAME OF PI			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
MOUNTAI	REHAB						
				В	LACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	<u>- 18</u>		380			
1 000	by staff involved in di			500			
		em for recording incidents acility's IPCP and the					
		lle, store, process, and s to prevent the spread of					
	IPCP and update the	view. Ict an annual review of its ir program, as necessary. is not met as evidenced					
	Based on observation interviews, the facility after touching resider and hair while assisti	n, record review and staff failed to sanitize hands nts and staff member's face ng residents with meal d dining room during 1 of 1			Nurse Aide #1 was identified during the meal service to not adhere to the facility expectation for infection prevention during the dining service as exhibited by not sanitizing hands after touching face, has and multiple residents before continuing with dining assistance. The facility	ty ring air,	
	entitled Infection Con employees must was	l: blicy dated June 2013 trol Meal Service specified h and/or use hand sanitizer ng other than items on the			expectations are reviewed during new education, annually thereafter, and as needed. Nurse Aide #1 was reeducat on 8/20/18 on facility procedure and expectation for providing services in a manner that will maintain an effective infection prevention and control progra	ed m	
	#1 was observed deli cart in the dining roor assistance with eating were seated in their g around a curved table as NA #1 delivered a	AM, Nursing Assistant (NA) vering meal trays from a tray n for residents that required g. Residents #2 and #23 geri chair and wheelchair e. On 08/20/18 at 11:57 PM meal tray to Resident #2, nt on his left shoulder. The			designed to provide a safe, sanitary an comfortable environment as it relates to assisting residents with dining services Nurse Aide #1 was provided education 8/20/18 by the Director of Nursing to sanitize hands after touching residents self, and/or any items other than the tra- Education was provided to Certified Nu	o s. i on s, ay.	

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		MEDICAID SERVICES					D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING				
							С
		345048	B. WING			08	/23/2018
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTAI	N RIDGE HEALTH AND	REHAB			1 OLD US HIGHWAY 70 EAST		
	1			BL	ACK MOUNTAIN, NC 28711		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 880	Continued From pag	ie 19	F 88	80			
		her hands before she			Aides and Administrative staff who ass	sist	
		a meal tray for Resident			with the meal service beginning 8/20/1		
	-	ver to get silver ware out of a			and completing 9/7/18 by the Staff		
	paper wrapper and r			Development Coordinator on the facilit	ty		
	of food, NA #1's long			policy for Infection Control during Mea	I		
	down on both sides of her face was observed				Service.		
	-	table and the top of the cover					
		d. While she set up trays for			Director of Nursing and/or designee		
		1 was observed using her left hanging down on the left side			inclusive of the Staff Development Nur Quality Assurance Nurse, and	se,	
	-	ck. She continued setting up			Administrator will audit five employees		
		rays without sanitizing her			daily five times per week for four week		
		own on the opposite side of			employees 2 times weekly for a period		
		still had not sanitized her			4 weeks, 5 employees 1 time weekly fe		
	hands. As NA #1 re	ached across the table using			weeks, 5 employees biweekly for 4		
		ide a spoonful of food to			weeks, and 5 employees monthly for 3		
		r hanging down by the right			months to ensure that proper infection		
		observed brushing the dining			prevention is utilized during the meal		
		erved again using her left			service. The findings will be reviewed		
		on the left side of her face A #1 placed her left hand on			weekly by the Administrator and any additional education or monitoring will	ho	
		outh as she reached across			implemented as necessary dependent		
		ht hand to provide a spoonful			the findings of the audit.	on	
		#23. The hair on the right					
		n brushed across the table.			The Director of Nursing is responsible	for	
		reaching under the table			implementing this Plan of Correction a	nd	
	-	nd tapped Resident #23's leg			reporting the findings to the Quality		
		ne in order to wake him. She			Assurance Performance Improvement		
		Resident #2 and Resident #23			(QAPI) Committee monthly. The QAP		
		lacing a hand to her face and canitizer. She was further			committee consists of, but not limited t	.0,	
		nes flipping the hair on the			the Director of Nursing, Administrator, Quality Assurance nurse, MDS Director	)r	
	left side of face to he				Staff Development Coordinator, Social		
					Worker, Activities Director, Dietary	•	
	During an interview	with NA #1 at 12:13 PM on			Manger, Maintenance Director, Medica	al	
		sked why she continued to			Records, Medical Director, and Pharm		
		er hair while assisting			Consultant. The audits will be reviewe	-	
		neal without sanitizing her			monthly and recommendations for		
	hands, she replied s				changes to the plan of correction will		

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STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	PLE CONSTRU	(X3) D.	NO. 0938-039 ATE SURVEY DMPLETED	
	345048			G		С	
		345048	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			08/23/2018	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 OLD US HIGHWAY 70 EAST				
MOUNTA	N RIDGE HEALTH AND I	REHAB		BLACK M			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			C	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 880	table. NA #1 offered did ask another staff hand sanitizer and a assisting the resident used both. At 12:18 PM on 08/20 (DON) was informed assisting Residents # meal. The DON state taught not to touch th assisting residents w sanitizer if touching a items. On 08/23/18 at 11:07 assisting residents w the residents or put th She added she exper manner so that it did opportunity of coming food. The DON added	allowing her hair to brush the no other explanation. She member in the room for hair tie and stopped ts until she obtained and 0/18, the Director of Nursing of NA #1's actions while #2 and #23 with the lunch ed all facility NAs had been heir hair or face while ith meals and to use hand anything other than meal tray 7 AM, the DON stated staff ith eating should not touch heir hands on their face. cted hair to be kept in a brush table tops or have an g in contact with residents'	F 8	occur compli The pl include monito substa	if the facility is not maintain iance with regulatory requi an of correction can be ch e additional education and pring to obtain and maintain antial compliance. of Compliance: Septembe	irements. langed to n	

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