STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345447	A. BUILDING _____ B. WING _____	C 01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD RIDGE REHAB AND CARE C	25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and physician interview, the facility failed to provide timely physician notification of a lack of	F 157	This Plan of Correction does not constitute an admission or agreement by provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and federal law. **F157** 1. Resident # 1 no longer resides at the facility. 2. All residents have the potential to be affected by this citation. A review of residents' medication records will be completed by 2/14/14 by the Director of Clinical Services, Assistant Director of Clinical Services and/or Nurse Manager.. DHSR NH L & C Black Mountain WRO Received FEB 18 2014 by: SKH	2/14/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas S. Hagen — TITLE: Executive Director — (X6) DATE: 2/14/14

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

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F 157	Continued From page 1 intravenous access for 1 of 3 residents requiring intravenous medications (Resident #1). Findings included: Review of a hospital discharge summary dated 01/14/14 revealed Resident #1 completed 8 days of a planned 14 day course of the intravenous (IV) antibiotic cefepime and was awaiting bed placement at the facility to complete his course of IV antibiotics and rehabilitation. Resident #1 was admitted to the facility on 01/14/14 with diagnoses including status post acute on chronic respiratory failure and bronchiectasis with ciprofloxacin-resistant pseudomonas and Escherichia coli respiratory infection.. Review of Resident #1's admission orders to the facility dated 01/14/14 included an order for cefepime, 1 gram dose to be administered IV every 8 hours for 5 days. His admission care plan included the problems of infection alert for pneumonia with medications as ordered. Another problem of pneumonia noted the intervention of administering antibiotics as ordered. Review of admission nursing notes dated 01/14/14 at 2:50 PM and signed by Nurse #1 revealed documentation of an IV catheter inserted into the Resident's peripheral left forearm with no redness, swelling, or drainage. Another nursing noted dated 01/14/14 at 8:00 PM and signed by Nurse #1 documented that, according to a hospital report and a date noted on the dressing covering the IV catheter, it had been in place over 72 hours and was removed. This note documented that an attempt to obtain new IV access was unsuccessful and the oncoming	F 157	3. Licensed Nurses will be in-serviced by the Director of Clinical Services, Assistant Director of Clinical Services and/or Nurse Manager on notifying responsible party and physician of significant changes in resident condition. This inservice will include if resident is unable to receive medication as ordered. 4. The Director of Clinical Services, Assistant Director of Clinical Services and/or Nurse Manager will conduct Quality Improvement monitoring of ten resident charts for notification of changes and medication records five times a week for one month, three times a week for two months, two times a week for one month and one time a week for one month. The results	

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F 157	Continued From page 2	F 157		

night shift nurse, Nurse #2, was informed of Resident #1's need for IV access. Another nursing note dated 01/15/14 at 2:10 PM and signed by Nurse #1 documented 3 attempts to start a new IV without success, with the attending physician and the Resident's pulmonologist notified. This note documented arrangements were made for a peripherally inserted central catheter (PICC) to be placed at the local hospital on 01/16/14.

On 01/23/14 at 9:04 AM Nurse #2 was phone interviewed. She stated she was told by the off going nurse, Nurse #1, that the Resident's IV catheter was removed because it was old. Nurse #2 stated on 01/15/14 at approximately 3:00 AM her 3 attempts to obtain IV access were unsuccessful. She stated she did not attempt earlier because there was no guarantee the IV antibiotic would arrive from the pharmacy, but when the IV antibiotic did arrive around 3:00 AM she made her attempts at establishing IV access. Nurse #2 stated she figured staff would be able to call on the day shift of 01/15/14 to get an appointment for PICC placement and she did not call a doctor at 4:00 AM to inform them of this as it made no sense to wake them up for this. She stated Nurse #1 received report and assumed care of Resident #1 on the morning of 01/15/14.

On 01/23/14 at 11:37 AM the medical director was phone interviewed. He stated his expectation that nurses should contact the physician if IV antibiotics could not be administered as ordered. He stated a nurse should have called him earlier to inform him of the lack of IV access. The medical director stated the night shift nurse should have called the on-call doctor after her unsuccessful attempts at

of the QI monitoring will be reported to the Quality Assurance Performance Improvement Committee for six months and/or until substantial compliance is obtained.

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F 157	Continued From page 3 IV access and could have received guidance, which may have included arranging for the PICC placement sooner than the 01/16/14 appointment. On 01/23/14 at 1:45 PM the administrator, director of nursing and regional director for clinical services were interviewed. They stated that after unsuccessful attempts at obtaining IV access, they would expect nurses to call the physician and utilize them for guidance. They stated Nurse #2 should have called the physician after her unsuccessful attempts at obtaining IV access on the morning of 01/15/14.	F 157		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to provide clean linen for 1 of 4 residents (Resident #3). The findings included: Resident #3 was admitted to the facility on 04/25/2007 with diagnoses of cerebral degeneration, coronary artery disease, hypertension and ischemic cardiomyopathy. The quarterly Minimum Data Set (MDS) dated 11/09/13 assessed her cognitive status as intact with no memory impairment and having	F 252	1. Resident # 3's linens were changed on 1/23/14. 2. All residents have the potential to be affected by this citation. A review of residents' rooms, including their linens, will be completed by 2/14/14 by the Director of Clinical Services, Assistant Director of Clinical Services and/or Nurse Manager. 3. Licensed Nurses and Nursing Assistants will be in-serviced by the Director of Clinical Services, Assistant Director of Clinical	2/14/14

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F 252	Continued From page 4 independent daily decision making skills. Resident #3 required extensive one person physical assist for most activities of daily living (ADL). Resident #3's care plan updated in 11/13 revealed all interventions associated with these problems were applicable to her condition and appropriate. During an observation on 01/22/14 at 1:30 PM, Resident #3 was sitting up in her wheelchair and eating her lunch. Her fitted bed sheet was observed with a large orange/red soiled area 1.5 inches in width by 5 inches in length as well as a long yellow colored substance the size of a pencil on top of the fitted bed sheet coming down the side of the sheet toward the bed frame. During an observation on 01/22/14 at 1:55 PM, Resident #3 was sitting up in her wheelchair and continued to eat at her meal.. Resident #3 stated she was not feeling very well and just not hungry. Her fitted bed sheet was observed with a large orange/red soiled area 1.5 inches in width by 5 inches in length, as well as a long yellow colored substance the size of a pencil on top of the fitted sheet coming down the side of the sheet toward the bed frame. Resident #3 acknowledged the soiled areas on her fitted sheet and stated that she was not sure what the soiled areas were but staff needed to change her linen. During an observation on 01/22/14 at 2:32 PM, the nursing assistant #1 (NA) entered the resident's room and removed her tray. During an observation on 01/22/14 at 3:10 PM, Resident #3 was lying in bed on top of both soiled areas, which were still visible, as Resident #3 rested her hand on part of the orange/red soiled	F 252	Services and/or Nurse Manager on the need to change linens as they become soiled to ensure a homelike environment. 4. The Director of Clinical Services, Assistant Director of Clinical Services and/or Nurse Manager will conduct Quality Improvement monitoring of ten resident rooms to ensure a homelike environment including clean sheets five times a week for one month, three times a week for two months, two times a week for one month and one time a week for one month. The results of the QI monitoring will be reported to the Quality Assurance Performance Improvement Committee for six months and/or until substantial compliance is obtained.	

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F 252	Continued From page 5 area. During an observation on 01/22/14 at 3:37 PM with Nurse #3, Resident #3 was lying on a large orange/red soiled area 1.5 inches in width by 5 inches in length, as well as a long yellow colored substance the size of a pencil on top of the fitted sheet coming down the side of the sheet toward the bed frame. During an interview on 01/22/14 at 3:37 PM, Nurse #3 stated Resident #3 had been ill and spitting up. She reported Resident #3 had red jello and a nutritional supplement on 01/22/14. She further stated the expectation would have been for whomever had assisted Resident#3 to bed to have changed her sheets prior to putting her to bed. Nurse #3 spoke to Resident #3 informing her the staff would change her sheets when she got up. Resident #3 replied to Nurse #3 to do whatever she needed to do. During an interview on 01/22/14 at 4:00 PM with the Director of Nursing (DON), the Administrator and Nurse #3 all present, Resident #3 was observed lying on a large orange/red soiled area 1.5 inches in width by 5 inches in length, as well as a long yellow colored substance the size of a pencil on top of the fitted sheet coming down the side of the sheet toward the bed frame. The DON acknowledged the soiled areas and stated the expectation would have been for the linen to be changed prior to Resident #3 being placed in her bed.	F 252		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	Continued From page 6 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to keep an emergency exit door, fire alarm pull and emergency egress override button clear of wheelchairs for 1 of 5 residential hallways. Findings included: On 01/22/14 at 9:10 AM, observation of an emergency exit at the end of D hall revealed 3 wheelchairs (WC) in a row, blocking the emergency exit door. Adjacent to the emergency exit on the right wall and blocked by one of the WC was a fire alarm pull and emergency egress override button. On 01/22/14 at 10:29 AM, observation of an emergency exit at the end of D hall revealed 3 WC in a row, blocking the emergency exit door. Adjacent to the emergency exit on the right wall and blocked by one of the WC was observed a fire alarm pull and emergency egress override button. A housekeeper was observed entering the resident room to the right and adjacent to the emergency exit. On 01/22/14 at 10:35 AM a housekeeper was observed entering the resident room to the right and another housekeeper entering the resident room to the left, both rooms adjacent to the emergency exit. Nurse #3 was	F 323	1. The wheelchairs were removed from the end of D hall. 2. All residents have the potential to be affected by this citation. A review of the facility emergency exit doors, fire alarm pulls and emergency egress override buttons to ensure that they are clear of wheelchairs and other equipment will be completed by 2/14/14 by the Executive Director and / or Maintenance Director. 3. All staff will be in-serviced by the Executive Director, Maintenance Director, Director of Clinical Services, Assistant Director of Clinical Services and/or Nurse Manager on keeping emergency exit doors, fire alarm pulls and emergency egress override buttons clear of wheelchairs and other equipment.	2/14/14

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F 323	Continued From page 7 observed standing at her medication cart, placed on the right side of the hall in the vicinity of the emergency exit. On 01/22/14 at 12:10 PM, observation of an emergency exit at the end of D hall revealed 2 WC in a row, blocking the emergency exit door. Adjacent to the emergency exit on the right wall and blocked by one of the WC was observed a fire alarm pull and emergency egress override button. Nurse #3 was observed standing at her medication cart, placed in the D hall with a direct line of vision of the emergency exit. On 01/22/14 at 2:30 PM a staff member was observed passing ice water with her cart on the right side of the hallway and in the vicinity of the emergency exit. Nurse #3 was observed standing at her medication cart, placed in the D hall with a direct line of vision of the emergency exit. On 01/22/13 at 3:37 PM, Nurse #3 was interviewed. Upon observation of 2 WC blocking the emergency exit door and adjacent fire alarm pull and emergency egress override button at the end of D hall, Nurse #3 stated residents in a room at the end of the hallway put them there because they felt there was not enough room in their room for WC. Nurse #3 stated the WC were not supposed to be in front of the emergency door exit. On 01/22/14 at 3:40 PM, the administrator and director of nursing were interviewed. Upon observation of 2 WC blocking the emergency exit door and adjacent fire alarm pull and emergency egress override button at the end of D hall, the administrator stated he expected emergency exits be free and clear of objects. He stated residents in the room to left of this emergency	F 323	4 The Executive Director and/ or Maintenance Director will conduct Quality Improvement monitoring of ten emergency exit doors/ fire alarm pulls and/ or emergency egress override buttons to ensure there is no equipment blocking these areas five times a week for one month, three times a week for two months, two times a week for one month and one time a week for one month. The results of the QI monitoring will be reported to the Quality Assurance Performance Improvement Committee for six months and/or until substantial compliance is obtained.	

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F 323	Continued From page 8 exit placed their WC in front of the emergency exit door but it was not acceptable. He stated he would have expected staff in the area of this emergency exit to have relocated these WC.	F 323		