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 08/29/2014

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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242		9/26/14

F 242 SS=D — 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES

The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident interview and staff interview, the facility failed to permit Resident #2 entry into the main dining room during a meal for 1 of 1 residents observed for choices. Findings included:

Resident #2 was readmitted to the facility on 09/12/13 with diagnoses including Alzheimer's disease, depressive disorder and anxiety state. Her annual Minimum Data Set assessment of 08/05/14 coded her with moderately impaired cognition and without moods or behaviors. Preferences for customary routines and activities noted the resident ranking as very important to do things with groups of people. Resident #2 required supervision and set up help for eating. Her care plan, last reviewed on 08/21/14, noted her at risk for social isolation related to a nursing home placement with an intervention to encourage the resident to attend and participate in out of room activities. An intervention for the problem of cognitive impairment and depression was to encourage the resident to attend activities that would increase interaction with others and to participate in conversation.

Provider's Plan of Correction (F 242):

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.

1. Resident #2 suffered no injury related to this citation.

2. All residents have the potential to be affected by this citation. An audit of Current residents to determine their preferred place to have meals was completed on 9/19/2014-9/24/2014 by the Director of Clinical Services, Nursing Supervisor, Social Services, Activities, Dietary Manager and Executive Director. The residents choice will be put on the residents tray cards and kardex.

3. Licensed Nurses, Certified Nurse assistants and Dietary aides were In serviced by the Social Services Director

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/25/2014

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 242	Continued From page 1 Review of Resident #2's medical record revealed an activity note documenting the resident enjoying socializing with others in common areas, usually in the main dining room. A social services progress review dated 07/04/14 noted in a psychosocial well-being assessment that the resident enjoyed all kinds of activities and got along well with others. A psychiatric mental health nurse practitioner note dated 07/07/14 quoted the resident as stating "I'm doing fine, I'm laughing and cutting up with the crowd." On 08/25/14 at 5:50 PM Nurse Aide #3 was interviewed and stated that when the last tray was served in the main dining room and any other residents were not seated at that time, their trays would be added to the hall carts and the residents were expected to eat in their rooms. She stated she thought there was a cut-off time, exceptions were made but usually that is how the cut-off worked. On 08/27/14 at 8:17 AM Resident #2 was observed seated in her wheelchair in the hallway and at the door to the main dining room. She was being told by a staff member blocked from view by a tray cart that she could not eat in the main dining room and to follow the tray cart back to her hallway where she could eat breakfast in her room. An ambulatory resident was observed pushing Resident #2 in her wheelchair back to her room. On 08/27/14 at 8:22 AM Resident #2 was observed eating breakfast in her room. On 08/27/14 at 9:00 AM was observed posted in the employee time on a bulletin board a laminated sign which stated all residents needed to be in the dining room by 7:15 AM for breakfast, 11:45 AM for lunch and 4:15 PM for dinner.	F 242	on resident□s right to make the choice where they dine on 9/19/2014-9/24/2014. The Executive Director, Dietary Manager, Customer Service Liaison and/or Nursing Supervisor will conduct Quality Improvement monitoring of residents choice of where to dine, 5 residents per meal five times a week for four weeks, 3 times a week two months, two times a week for two months and one time a week for one month. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Directors of Nursing, Activities,Medical Director, Social Services,Maintenance Director, and Minimum Data Assessment Nurse.	

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F 242	Continued From page 2 On 08/27/14 at 10:30 AM Resident #2 was observed participating in an activity in the main dining room. On 08/27/14 at 11:30 AM she was observed seated at a table in the main dining room with other residents and she stated she was at an activity, remained in the dining room and was now waiting for lunch. On 08/28/14 at 8:10 AM Resident #2 was observed seated in the main dining room at a table with other residents eating breakfast. On 08/28/14 at 11:00 AM she was again observed seated in the main dining room at table with other residents eating lunch. On 08/28/14 at 11:10 PM Resident #2 was interviewed and stated the facility was a nice place and she made friends with a lot of people. She stated she attended activities regularly and had to see what was going on. She stated she ate in the main dining room for her meals and she hardly ever ate in her room. She stated that once in a while staff would tell her she had to eat a meal in her room but she did not know why they would tell her that. She stated she would rather eat in the dining room as she and her friends had fun and could socialize. She stated she was bothered when she was told to eat in her room. She stated sometimes staff would make an exception and let her eat in the dining room, but sometimes she was told she could not even though she saw others come and they were allowed to eat in the dining room. On 08/29/14 at 1:31 PM an interview with Dietary Aide (DA) #1 and the Food Service Director (FSD) revealed nursing staff were responsible for getting residents to the dining rooms. They	F 242		

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F 242	Continued From page 3 stated times for meals were posted by which residents had to get to their meals but that some residents came early who then might leave before the meal is served and then they return and a tray is put together. They stated they would love for all residents to come to the dining room and they did have a meal cut-off time for dining room service because it was not fair for residents taking meals on the halls to not get their meals at their expected time. They stated if a resident did show up late after the cut-off time staff would let them come in. They stated nursing staff would have to be with the residents in the dining room if they came in at other times other as the DAs leave the kitchen to set up the dining room and take out carts. The FSD stated she was made aware of another resident who was turned away and her response was not to turn anyone away. She stated this expectation was communicated to the dietary staff, the director of nursing and some of the nurse aides who mainly work the dining room, but she stated the communication was word of mouth. The DA and FSD stated that this was not the norm.	F 242		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to keep clean and in good repair walls, floors, resident care equipment, a faucet, an electrical outlet and furniture, and failed to	F 253	1. No residents were injured related to this citation. Common shower room outside locked door to A hallway had tile replaced, areas	9/26/14

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F 253	Continued From page 4 address room clutter for 10 of 58 resident rooms and 2 of 4 common shower rooms (Rooms A101, A105, A107, C130, C135 bed A, C138, D139, D150, E160 and E163 and shower rooms located outside of and inside locked unit A). Findings included: During staff interviews and a facility tour on 06/20/14 from 2:23 PM to 3:44 PM with the Housekeeping Supervisor (HS) and Maintenance Director (MD), the following environmental concerns were observed: a. In the common shower room located immediately outside the locked door to A hallway, missing ceramic tile was observed on a corner at the baseboard and brown stains with peeling areas was noted on the ceiling b. In the common shower room located inside the locked door of A hallway, cracked laminate was observed on the front of a toilet seat. Attached to this toilet was a metal handle for support that was observed as wobbly. Brown/black staining was noted to grout at the junction of the floor and wall in a shower enclosure. A ground fault outlet was observed with the plastic test button completely loose from the outlet c. In Room A101, the floor around the toilet in the shared bathroom was observed with heavy and dark yellow discoloration. A missing drawer pull was observed missing on a wardrobe d. In Room A105, the grill in the package terminal air conditioner (PTAC) unit was observed with breaks with sharp edges. The toilet was observed with a yellow ring of stain	F 253	on ceiling painted on 09/02/2014 by the Maintenance Director. Common shower room inside the locked door on the A hallway had toilet seat repaired, the was secured, ground fault outlet was repaired and grout cleaned on 09/02/2014 by the Maintenance Director. In room A101 the drawer pull was applied on 09/02/2014 by the Maintenance Director. In room A101 the area round the toilet had new tiles applied on 09/08/2014 by the Maintenance Director. In room A105 the grill in the terminal air conditioner was replaced on 09/09/2014 by the Maintenance Director. In room A106 bathroom had new tile applied on 09/06/2014. In room A107 the grill in the terminal air conditioner was replaced on 09/09/2014 by the Maintenance Director. In room C135A stuffed animals were removed from the light on 08/29/2014 by the Director of Clinical Services. Resident residing in C135A had their wheelchair armrest repaired on 09/02/2014 by the Maintenance Director. Resident residing in C130A had their wheelchair armrest repaired on 09/02/2014 by the Maintenance Director. In room C138A had residents personal items de cluttered and stored on 09/24/2014 by the Executive Director. In room D139 bathroom tile was replaced on 09/03/2014 by the Maintenance Director. Sink handle was tightened and rust staining in bowl was corrected on 09/24/2014 by the Maintenance Director. In room D150 the grill in the terminal air conditioner was replaced on 09/09/2014 by the Maintenance Director. Tiles around toilet	

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F 253	Continued From page 5 e. In Room A107, the PTAC unit was observed with a broken grill f. In Room C135 bed A, multiple stuffed animals were observed on the light fixture over the bed and on the wall over the bed was observed shelving with other items. During the tour, the MD and Director of Nursing informed the resident the stuff animals had to be removed. The armrests on the wheelchair (WC) for this resident were noted with cracking g. In Room C130 bed A, an armrest on the resident's WC was observed with cracked and peeling vinyl h. In Room C138 bed A, personal resident items were observed cluttered and packed around the bed i. In Room D139, loose and stained floor tile was observed along the baseboard and under the sink in the bathroom. The sink faucet and handle were noted as loose in the sink, the faucet was dripping and rust staining was noted from faucet down inside the bowl of the sink j. Room D150, the metal vent of the PTAC unit under the plastic grill was covered in dust. Stained floor tiles were observed at the base of the toilet k. In Room E160, missing and cracked ceramic tile was observed at corner of the shower enclosure where the floor and wall met l. In Room E163, a light fixture in the ceiling of the shower enclosure was noted as yellowed and with darkened areas	F 253	in room D150 were replaced on 09/04/2014. In room E160 tile was replaced on 09/04/2014 by the Maintenance Director. The Maintenance Director was in serviced by the Executive Director on 09/24/2014 on completing and identified maintenance issues timely. The Housekeeping Supervisor was in serviced on ensuring the cleanliness of the facility on 09/24/2014 by the Executive Director. 2. All residents have the potential to be affected by this citation. Observations of resident living areas were performed 08/29/2014-09/24/2014 by the Maintenance Director, Housekeeping Supervisor, Executive Director, Director of Clinical Services, Nursing Supervisor, Social Services, Activities. 3. Licensed Nurses, Certified Nurse Assistants, Social Services, Activities, Business office, Housekeeping, Dietary staff were in serviced on when maintenance or housekeeping issues have been identified to fill out a maintenance request form for maintenance issues and notify housekeeping with housekeeping concerns. The Maintenance Director, Housekeeping Supervisor, Executive Director and/or designee will conduct Quality Improvement monitoring of resident living areas for maintenance and housekeeping issues five times a week for four weeks, three times a week for two months, two times a week for two months one time a week for one month.	

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F 253	Continued From page 6 On 08/29/14 at 2:23 PM an interview with the HS revealed he expected housekeepers to inform him or the MD of any maintenance concerns and he believed them to be knowledgeable of concerns and empowered to report them. He stated WCs were cleaned by housekeeping staff on the third shift by himself and the floor technician who assisted. He stated if WCs presented with mechanical issues or wear and tear issues the MD was notified. On 08/29/14 at 2:23 PM and during the interview with the HS, the MD arrived and on interview stated staff reported maintenance issues using written work orders kept at the nursing station. He stated he worked through the requests, placing priority on WC brakes, bed rails, toilets and plumbing. He stated that every morning before morning meetings, department heads as part of a "guardian angel" program reviewed assigned resident rooms using a checklist, looking at nursing, maintenance, housekeeping and oxygen delivery. The MD stated that other than discussion of repainting hallways, removing wallpaper and a renovation of therapy, there were no ongoing projects. He stated PTAC units were cleaned by vacuuming once a month and the coils cleaned once a year. He stated the facility has tried to order replacement parts but the units are very old and parts difficult to come by. He stated the facility has been buying new PTAC units a couple times a year and currently has two in the storage shed to replace out old units. He stated he could perform ceramic tile repair himself and would expect staff to report this using a work order. He stated clutter in resident rooms was a constant battle which was reported to the social worker who called families to address it	F 253	4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Directors of Nursing , Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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F 253	Continued From page 7 with the facility. He and the HS stated housekeeping staff addressed stained floor tiles with bleach, grout cleaner and with pressure washing and he also changed out bathroom floor tiles as needed. They stated bathroom floors was sealed with wax but urine still was able to penetrate it. The MD stated light fixtures and loose or leaky faucets should have been reported by staff.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide wound care twice daily as ordered by the physician for 1 or 4 residents reviewed for wound treatments (Resident #109). The findings included: Resident #109 was admitted to the facility 01/15/14 and readmitted 07/19/14 and 08/18/14. The resident's diagnoses included a below the knee amputation related to vascular insufficiency, unhealing stump wound, end stage renal disease, and diabetes mellitus.	F 309	1. Resident #109 no longer reside at the facility. Nurse #1 was in serviced on following physician orders by the Director of Clinical Services on 09/23/2014. 2. Residents with wounds have the potential to be affected by this citation. An audit of resident with wound care was completed on 09/24/2014 for following physician orders and transcribing orders to the treatment record by the Director of Clinical Services and/or Nursing Supervisor. 3. Licensed Nurses were in-serviced by	9/26/14

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F 309 Continued From page 8

A care plan updated 05/14/14 identified a non-pressure related stump wound on Resident #109's left leg. The care plan goal specified the wound would be healed by the next 90 day review. Interventions included nurses should administer treatments as ordered by the physician.

A quarterly Minimum Data Set (MDS) dated 05/27/14 indicated the resident's cognition was intact. The MDS specified the resident had an open lesion that required a nonsurgical dressing with the application of medication.

A review of Resident #109's medical record revealed a wound physician's consult report dated 06/26/14. The report specified beginning 06/30/14, if available use an iodine gel product under gauze (dressing for stump wound) and secure with tape. Change dressing 2 times a week. If the gel was unavailable, use gentamycin ointment twice daily. The report contained the Medical Director's initials indicating the wound care physician's orders were acceptable for this resident. No telephone order containing the above instructions was found in the resident's medical record.

A review was conducted of Resident #109's treatment administration records (TAR) dated 06/01/14 through 06/30/14. The treatment orders for the stump wound were handwritten to use the iodine gel product under gauze and secure with tape 2 times a week. If unavailable use gentamycin ointment.

An additional wound physician consult report dated 07/02/14 specified to follow the orders as written on 06/26/14. This order also specified to

F 309

the Director of Clinical Services, and/or Nursing Supervisor of following physician orders and transcribing orders from to the treatment record and transcribing orders from consulting physician□s accurately 9/19/2014-9/24/2014.
The Director of Clinical Services and/or Nursing Supervisor will conduct Quality Improvement monitoring of residents with wounds comparing physician orders, consult sheets and treatment 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 1 month.

4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Directors of Nursing , Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.

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F 309	Continued From page 9 apply the iodine gel product or another named iodine product under gauze and change 2 times a week. If the iodine gel or the other iodine product was not available, use gentamycin ointment twice daily. This consult report contained the Nurse Practitioner's initials indicating the wound care physician's orders were acceptable for this resident. No telephone order containing the above instructions was found in the resident ' s medical record. A review of the TAR dated 07/01/14 through 07/31/14 revealed the order was handwritten to use the iodine gel under gauze and secure with tape 2 times a week. If unavailable, use gentamycin ointment. Nurses' initials on the TAR indicated the treatment with gentamycin was done 2 times a week while the resident was in the facility. A review was conducted of the TAR dated 08/01/14 through 08/30/14. The treatment of the stump wound remained as documented on the 07/01/14 through 07/30/14 and was handwritten as well. The August TAR contained nurses' initials indicating the treatment with gentamycin was done 2 times per week. An observation of Resident #109's stump wound was conducted on 08/27/14 at 12:25 PM. Nurse #1, who frequently worked with Resident #109, removed the dressing. The wound was observed without signs or symptoms of infection and no odor was noted. Nurse #1 stated after cleansing, she would apply gentamycin ointment. She stated at this time, the resident was on her way to the shower. The wound would be washed with soap and water and the gentamycin would be applied after her shower. The nurse stated the	F 309		

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F 309	Continued From page 10 gentamycin ointment was applied twice a week with dressing changes. An interview with the Director of Nursing (DON) was conducted on 08/29/14 at 8:16 AM. The DON acknowledged the dressing change with gentamycin should have been done twice daily not twice a week. She stated this was due to a transcription error. She confirmed with her supply coordinator that the iodine gel product had never been ordered for twice a week dressing changes. An interview was conducted with the Medical Director on 08/29/14 at 1:00 PM. He stated Resident #109's stump wound was not harmed by the gentamycin ointment being applied twice a week instead of twice a day since 06/30/14.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide personal hygiene for dependent residents in need of shaving and finger nail care for 2 of 6 residents reviewed for activities of daily living (Resident #76 and #13). Findings included: 1. Resident #76 was admitted to the facility on 01/31/14 with diagnoses including dementia,	F 312	1. Resident #76 had facial hair removed by Certified Nurse Assistant on 8/28/2014. Resident #13 had nail care and facial hair removal on 8/28/2014 by a Certified Nurse Assistant. Certified Nurse Assistant #1 was in serviced by the Director of Clinical Services on providing nail care and facial hair grooming to female residents on	9/26/14

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	345447	A. BUILDING ______ B. WING ______	C 08/29/2014

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

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F 312	Continued From page 11 episodic mood disorder and anxiety. Her most recent Minimum Data Set assessment dated 08/07/14 revealed severely impaired cognition but able to be understood and to understand. She was coded as having no delirium, moods, behaviors nor any rejection of care. Resident #76 required extensive 1 person assistance with personal hygiene. Her care plan, last reviewed on 08/21/14 revealed a self-care deficit with instructions for no further showers but rather to give complete bed baths daily. No activity of daily living (ADL) interventions were noted for the problem of anxiety with episodes of combative behavior. Interventions for the problem of refusal of care included offering the resident a choice, providing alternatives and when care was refused to go back later and offer it again. Review of Resident #76's medical record revealed a psychiatric mental health nurse practitioner consult date 07/21/14 documenting staff reports of resident irritability, anxiety and as being grumpy, but the assessment finding "noncompliance with treatment" was noted as not being applicable and the resident as being cooperative. A nursing note dated 07/30/14 revealed a nurse aide (NA) attempted to dress Resident #76 and was scratched. Another note dated 08/11/14 revealed that the resident did like to be changed at times. Another note dated 08/19/14 documented the resident could be combative with ADL and transfers with attempts to kick, hit and bite staff at times. Another note dated 08/27/14 revealed an NA proceeded with incontinence care when the resident became agitated and hit the NA in the nose with her knee, after which the NA returned to finish care. On 08/26/14 at 9:45 AM, Resident #76 was	F 312	09/24/2014 2. All residents have the potential to be affected by this citation. Observations of female resident facial hair, and nail care of residents was completed 9/19/2014--9/24/2014 by the Director of Clinical Services, Nursing Supervisor, Social Services, Executive Director, Activities. 3. Licensed nurses were in serviced by the Director of Nursing and/or Nursing Supervisor on ensuing that certified nurse aides completed nail care and facial grooming of female residents on 9/19/2014-9/24/2014. Certified nurse aide assistants were in serviced by the Director of Nursing and/or Nursing supervisor on completing facial hair groom of female residents and providing nail care to residents 9/19/2014. The Director of Clinical Services and/or Nursing Supervisor will conduct Quality Improvement monitoring of female residents for facial hair 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 1 month. The Director of Clinical Services and/or Nursing Supervisor, Activities, Social Services, Executive Director will conduct Quality Improvement monitoring of residents nail care 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 1month 4.The results of these audits will be reported to the Quality Assurance	

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F 312	Continued From page 12 observed in her wheelchair, conversant and confused with a calm affect, presenting with numerous chin hairs approximately 1/8 inches long. This same observation was also noted on 08/26/14 at 4:42 PM, 08/27/14 at 7:40 AM, 08/27/14 at 12:20 PM, 08/27/14 at 4:10 PM, 08/28/14 at 8:15 AM and 08/28/14 at 1:15 PM. On 08/28/14 at 1:23 PM an interview with NA #4 revealed facial hair removal and nail care were addressed on shower days and as needed. She stated Resident #76 got anxious and combative sometimes but that this was more "sundowners." She stated residents received "all the basics" in ADL and facial hair removal was put lower on the priority list. She stated NAs did change of shift reports with off-going staff but facial hair removal was not discussed for this resident. On 08/28/14 at 1:30 PM NA #4 was observed approaching Resident #76 and stated the resident did have visible facial hair that needed attention. NA #4 was observed speaking to Resident #76, the resident remained calm and upon being told about her facial hair the resident started rubbing her chin, neck and jaw and stated she thought it was time to trim her facial hairs. On 08/28/14 at 1:41 PM an interview with the Director of Nursing (DON) revealed her expectation that NA provided facial hair care during showers or any time it needed to be done. The DON explained if an NA was unable to complete any care that it was reported to the oncoming shift to be completed. On 08/28/14 at 2:50 PM an interview with the Assistant Director of Nursing (ADON) revealed males indicated their preference for shaving and	F 312	Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Directors of Nursing , Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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F 312	Continued From page 13 some females did not want staff to touch their face. He stated facial hair removal should be addressed whenever the need presented and if removal was refused he expected this was documented. 2. Resident #13 was admitted to the facility on 06/05/12 with diagnoses which included lack of coordination, Alzheimer's, muscle weakness, and altered mental status. The Quarterly Minimum Data Set (MDS) dated 07/01/14 indicated her cognition was severely impaired for daily decision making skills but was not coded for any rejection of care. The MDS further coded Resident #13 with behaviors of inattention and disorganized thinking that were continuously present. The MDS specified Resident #13 required extensive assistance with activities of daily living (ADL) including personal hygiene. A review of the care plan with a revised date of 07/31/14 indicated a problem statement of self care deficit that Resident #13 required total assistance with ADLs related to bathing and grooming. The goal was for Resident #13 to remain clean and well groomed with interventions which included provide full assistance to shower 2-3 times weekly and provide personal hygiene care. On 08/25/14 at 4:17 PM Resident #13 was observed in her room sitting in her recliner chair. All of Resident #13's fingernails were observed with ragged, uneven edges with a brown substance under all the nails and approximately ¼ inch long gray hairs were observed on her chin.	F 312		

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F 312	Continued From page 14	F 312		

On 08/26/14 at 8:55 AM Resident #13 was observed in her room sitting in her recliner chair. All of Resident #13's fingernails were observed with ragged, uneven edges with a brown substance under all the nails and approximately ¼ inch long gray hairs were observed on her chin.

On 08/27/14 at 10:50 AM Resident #13 was observed in her room sitting in her recliner chair. All of Resident #13's fingernails were observed with ragged, uneven edges with a brown substance under all the nails and approximately ¼ inch long gray hairs were observed on her chin.

On 08/28/14 at 7:49 AM Resident #13 was observed sitting in her recliner chair that was outside the doorway of the restorative dining room. Resident #13's fingernails remained untrimmed with brown substance under the nails and the facial hair remained unshaven.

On 08/28/14 at 1:17 PM an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated she provided Resident #13 with a shower on Wednesday morning but stated she had not provided fingernail care and shaving. NA #1 further stated shower care included shampooing the hair, shaving facial hair, cleaning and trimming fingernails and applying powders or lotions. NA #1 explained facial hair shaving and fingernail care should be completed as needed as well as during showers. NA # 1 revealed Resident #13 was agitated at times but had never been combative with her in the shower. NA #1 further revealed she was able to calm Resident #13 by redirecting and talking to her. NA #1 verified she had not completed the ADL care of shaving and fingernail cleaning for Resident #13.

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F 312	Continued From page 15 On 08/28/14 at 1:26 PM an Interview was conducted with Nurse #4. Nurse #4 stated she was familiar with the care provided for Resident #13. Nurse #4 explained it was her responsibility to ensure the NAs provided the care for Resident #13 that was care planned. Nurse #4 further explained that fingernails were cleaned and facial hair shaved during showers and as needed. Nurse #4 observed Resident #13 and confirmed grooming was not completed for nail care and facial hair removal for Resident #13. On 08/28/14 at 1:41 PM an interview was conducted with the Director of Nursing (DON). The DON observed Resident #13 and confirmed the resident needed her nails cleaned and trimmed and her facial hair on the chin shaved. The DON verified that the care was not completed and that it was her expectation the NAs provided the care during showers or any time it needed to be done. The DON explained if an NA was unable to complete any care that it was reported to the oncoming shift to be completed.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		9/26/14

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F 323	Continued From page 16 Based on observations record reviews and staff interviews the facility failed to secure a ½ side rail on a bed and failed 2 of 4 sampled residents reviewed for accidents and hazards (Resident #104 and Resident #49). 1. Resident #104 was admitted to the facility on 02//11/13 with diagnoses which included lack of coordination, Alzheimer 's, generalized muscle weakness, difficulty walking, anxiety, and others. The Quarterly Minimum Data Set (MDS) dated 06/24/14 indicated her cognition was severely impaired for daily decision making skills but was not coded for any rejection of care. The MDS specified Resident #13 required extensive assistance with activities of daily living (ADL) including transfers and bed mobility. On 08/26/14 at 1:55 PM Resident #104 was observed resting in bed with the head of the bed raised. She had ½ side rails attached to both sides of the top of the bed. The left side rail was noted to be loose and was able to be pulled away from the bed approximately 8 to 10 inches back and forth. On 08/27/14 at 8:30 AM Resident # 104 was again observed resting in bed with the head of the bed raised. The left side rail was noted to remain loose and was able to be pulled away from the bed approximately 8 to 10 inches back and forth. On 08/28/14 at 8:33 AM 2 Nursing Assistants (NAs) were observed to reposition Resident #104 in bed in a sitting up position for her meal and provide her breakfast meal tray set up. The side rails were raised up on both sides of the bed. The left side rail was noted to remain loose and	F 323	1. Resident #104 side rail was secured by Maintenance Director on 08/29/2014. Resident #49□s room had the extension cord, 4 socket wall outlet removed from the room by the Maintenance Director on08/29/2014. The Maintenance Director was in serviced by the Executive Director on 9/24/2014 on usage of extension cords and 4 socket wall outlets. 2. All residents have the potential to be affected by the citation. The Maintenance Director audited side rails on 08/28/2014. The Maintenance Director and Environmental Director, Executive Director made observations 9/19/2014-9/24/2014 for extension cords and 4 socket wall outlets. 3. Licensed Nurses, Certified Nurse Assistants, Dietary, Environmental Services, Social Services, Activities, Business Office, Minimum Data Assessment Nurse were in serviced by the Director of Clinical Services on filling out Maintenance work orders for any identified issues within the facility timely, side rail issues were to be called to the Maintenance Director and Executive Director immediately. The Maintenance Director, Environmental Services Director and/or Executive Director will do Quality Improvement monitoring of 10 residents rooms for use of extension cords, and 4 socket wall outlets five times a week for one month, three times a week for two months, two	

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F 323	Continued From page 17 was able to be pulled away from the bed approximately 8 to 10 inches back and forth. On 08/28/14 at 9:40 AM NA# 2 was interviewed. NA #2 stated she was familiar with the care provided for Resident #104. NA #2 observed the loose side rail and proceeded to tighten the screw locking mechanism. The side rail screw mechanism was observed to not tighten and the side rail remained lose and still wobbling back and forth. NA #2 explained that when equipment was not working properly a work order was completed for the Environmental Maintenance Director (EMD) and placed in his box at the nurses ' station. NA#2 confirmed that the side rail wasn ' t working properly ad she had not placed a work order for repairs. On 08/28/14 at 12:00 PM the Director of Nursing (DON) and theEMD were interviewed. The EMD explained the staff should complete a work order and place it in his box at the nursing station for any needed repairs. The EMD further explained he checked the box throughout the day and completed repairs. The DON and the EMD observed Resident #104 ' s left side rail. The EMD and DON confirmed the side rail was loose and needed repair. The DON and the EMD confirmed that they expected all side rails to be attached correctly to beds to prevent accidents from occurring. 2. Resident #49 was admitted to the facility on 11/13/11 with diagnoses including Alzheimer ' s disease, history of cerebrovascular accident and a seizure disorder. His most recent Minimum Data Set dated 07/01/14 noted him to be cognitively intact.	F 323	times a week for one month and one time a week for one month and/or until substantial compliance is obtained. 4. The Results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Directors of Nursing, Medical Director, Education Coordinator,Social Services, Maintenance Director and Minimum Data Assessment Nurse.	

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F 323	Continued From page 18 During an observation of Resident #49 ' s room on 08/25/14 at 3:48 AM, an orange, heavy gauge extension cord was observed plugged into a 4 socket wall outlet approximately 3 feet off the floor and above his bed. This cord was coiled under the foot of the resident ' s bed with the foot of the bed against the wall. Into this extension cord was plugged a surge protector and plugged into the surge protector was a second surge protector. Into both these surge protectors were plugged numerous plugs. Located next to the foot of the bed on a bedside table was observed a television (TV), digital video disc (DVD) player, desk lamp and on the floor was an oxygen concentrator. This observation was made again on 08/26/14 at 11:00 AM. On 08/29/14 at 2:23 PM an interview with the Housekeeping Supervisor revealed his expectation that housekeepers report to him or Maintenance any facility concerns. He stated he felt housekeepers were knowledgeable about these things and empowered to report them. He stated housekeeping staff deep-cleaned resident rooms once a month which included cleaning bed frames and moving furniture to clean floors. During this interview, the Housekeeping Supervisor was joined by the Maintenance Director. The Maintenance Director stated all staff could report maintenance concerns on work order slips available at the nursing station. He stated every morning before morning meetings, department heads would look at their assigned rooms under the " guardian angel " program and used a checklist to address nursing concerns, maintenance issues, oxygen delivery and housekeeping issues. He stated facility policy did not permit use of extension cords but surge protectors approved by Underwriters Laboratories	F 323		

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F 323	Continued From page 19 (UL) were permitted. On 08/29/14 at 3:44 PM an environment tour with the Housekeeping Supervisor and Maintenance Director was concluded. During the tour, observation of Resident #49 ' s room revealed an orange, heavy gauge extension cord plugged into a 4 socket wall outlet approximately 3 feet off the floor and above the resident ' s bed. This cord was coiled under the foot of the resident ' s bed with the foot of the bed against the wall. Into this extension cord was plugged was plugged a surge protector and plugged into the surge protector was a second surge protector. Into both these surge protectors were plugged numerous plugs. The Maintenance Director confirmed the following electrical devices were plugged into the surge protectors: a TV, a DVD player, a cable TV box, a cell phone charger, a desk lamp and an oxygen concentrator. The Maintenance Director stated this was not acceptable and would be fixed immediately.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		9/26/14

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F 371	Continued From page 20 Based on observations record reviews and staff interviews the facility failed to date thawed nutritional supplements and thawed meats and securely seal items in the freezer and dry storage area for resident consumption. The findings included: During the initial tour of the kitchen on 08/25/14 at 2:00 PM the dry food storage area, freezer and refrigerators were observed. The unlabeled and unsealed items were observed as follows: a. Two 5 pound packages of thawed hamburger meat with an expired manufacturer ' s use by date of 08/18/14 were observed stored on the bottom shelf of the walk in refrigerator. There was no label on either package of hamburger to indicate when they were taken from the freezer and stored in the refrigerator. b. One unopened thawed 14 pound ham stored on the bottom shelf of the walk in refrigerator was not labeled or dated when it was removed from the original storage carton or taken from the freezer for thawing. There was no manufacturer use by date on the ham. c. In the Kitchen refrigerators nine individual cartons of vanilla nutritional shakes on a tray and a full case of individual cartons of strawberry shakes were not labeled and did not indicate when they expired and/or when they were placed in the refrigerator storage. d. Three flats of pasteurized eggs that were not stored in their original carton were in the walk in refrigerator. There was no dated label on the egg trays. e. An unsealed bag of veal steaks in the freezer. f. An unsealed bag of fish fillets in the freezer. g. An unsealed ½ full 50 pound bag of flour in	F 371	1. No residents were injured related to this citation. Two five pound packages of hamburger meat were removed from the cooler on 8/25/2014 by the Food Service Director. One thawed 14 pound ham was removed from the cooler on 8/25/2014 by the Food Service Director. Two five pound packages of hamburger meat removed from the cooler on 8/25/2014 by the Food Service Director. Nine individual cartons of vanilla nutritional shakes, and a full case of individual cartons of strawberry shakes were removed from the cooler on 8/25/2014 by the Food Service Director. Three flats of eggs were removed from the cooler on 8/25/2014 by the Food Service Director. An unsealed bag of veal steaks were removed from the freezer on 8/25/2014 by the Food Service Director. An unsealed bag of fish fillets were removed from the freezer on 8/25/2014 by the Food Service Director. An unsealed 50 pound bag of flour in the dry storage room was removed on 8/25/2014 by the Food Service Director. The Food Service Director was in serviced by the Regional Director of Nutritional Services on proper storage of food on 8/25/2014. 2. All residents have the potential to be affected by this citation. Observations of food items being stored in cooler, freezer, and dry storage area was completed on09/01/2014-09/24/2014 checking for dates and sealed containers by the Food	

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EMERALD RIDGE REHAB AND CARE C	25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804

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F 371	Continued From page 21 the dry storage room. An interview with the Food Service Director (FSD) on 08/25/14 at 3:00 PM revealed the frozen shakes were usually taken from the freezer and placed in the refrigerator to thaw before they were distributed to the residents. The FSD reported she was not aware the frozen shakes didn't have an expiration date and verified they were not dated when the dietary staff removed them from the freezer. The FSD explained that meats were normally taken from the freezer for thawing the day before they were to be served, should have been dated when removed from the freezer, and used within 3 days of thawing. She further explained the eggs should not have been taken from the original dated carton and should have been dated since they were taken from the original box with a use by date. The FSD revealed the open bags of frozen fish and veal steaks in the freezer and the open bag of flour in the dry storage all should have been securely wrapped and sealed. The FSD verified the thawed food items observed were not properly labeled with dates and the opened bagged foods were not securely wrapped and sealed. During interview with the Registered Dietician (RD) on 08/27/14 at 4:00 PM she stated that all foods should be dated when taken from the freezer for thawing. The RD further stated frozen shakes could be stored in the cooler for 7 days after thawed and should then be discarded. The RD explained all food items should be properly wrapped, securely sealed and labeled with the dates when opened for thawing.	F 371	Service Director and/or Executive Director. 3. The Food Service Director in serviced the dietary aides and cooks on proper dating of food products and sealing of boxes, bags and containers on 8/25/2014. The Executive Director and/or Food Service Manager will conduct Quality Improvement Monitoring of food expiration dates and storage 5 times a week for 1 month, 3 times a week for 2 months then 2 times a week for 1 month then 1 time a week for 1 month and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Nursing , Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		9/26/14

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 08/29/2014

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

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F 431	Continued From page 22 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to remove from use a	F 431	1. Resident #84 was not injured related to this citation.	

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F 431	Continued From page 23 vial of insulin opened longer than manufacturer's recommendation for Resident #84, from 1 of 5 observed medication carts reviewed for medication storage. Findings included: Review of the prescribing information for the medication insulin glargine, provided by the manufacturer with a revision date of October 2013, revealed directions that after being opened for 28 days the insulin must be discarded. Resident #84 was admitted to the facility on 12/20/12 with diagnoses including type 2 diabetes mellitus (DM). Review of her most recent Minimum Data Set dated 07/01/14 revealed her to have received insulin on all 7 days of the assessment period. Review of her care plan dated 08/21/14 revealed the problem of diabetes with appropriate interventions. Review of medical orders dated 07/01/14 directed the administration of insulin glargine, 100units/1 milliliter (ml) vial, inject 38 units subcutaneously (SQ) every night at bedtime (q HS) for a diagnosis of DM. On 08/29/14 at 7:15 AM Nurse #6 and the Director of Nursing (DON) were present for a review of the medication cart on the B hallway. A plastic pill container with a prescription label showing Resident #84's name and containing a vial of insulin glargine was observed in the medication cart. On the pill container was noted an orange preprinted label to note the date the vial was open, which was blank. On the vial was noted a small pharmacy label with the resident's printed name and in black ink the handwritten date of 07/27/14. Both Nurse #6 and the DON stated 07/27/14 was the date the vial was opened and that insulin was usually good for 28 days, but some insulins might be good for a longer period.	F 431	Nurse #6 was in serviced by the Director of Clinical Services on proper dating of insulin bottles and expiration dates of insulin on 09/24/2014. 2. Residents that take insulin have the potential to be affected by this citation. An audit of insulin□s for expiration dates was completed by the Director of Clinical Services and/or Assistant Director of Clinical Services on 09/24/2014. 3. Licensed nurses were in serviced by the Director of Clinical Services and/or Nursing supervisor on checking expiration dates on insulin on 9/19/9/24/2014. The Director of Clinical Services and/or Nursing Supervisor will conduct Quality Improvement monitoring of insulin expirations 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. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Directors of Nursing , Medical Director, Social Services, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse.	

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F 431	Continued From page 24 The DON stated she would confirm this date this with the pharmacy and she removed the insulin vial with the plastic container from the medication cart. The 28th day after opening this vial was determined to be 08/24/14. On 08/29/14 at 7:27 AM, a review of Resident #84's August 2014 medication administration record with Nurse #6 present revealed insulin glargine, 100units/1 (ml) vial, 38 units SQ q HS was noted as administered throughout the month including the period after the 28th day of opening the vial from 08/25/14 through 08/28/14. Nurse #6 stated he was instructed during orientation to note the date on the vial when insulin was opened and his practice was to check this every time he went to dispense the insulin to make sure the vial had not gone past the 28 day mark. On 08/29/14 at 7:50 AM an interview with the DON revealed she expected nurses to check for the 28th day mark when administering insulin. She stated the prescription label placed on the vial by the pharmacy had a refill date that occurred days before the 28th day and the nurse should use this information as a reminder the 28th day is approaching.	F 431		