STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345447	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 8/13/2015

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 356	483.30(e) POSTED NURSE STAFFING INFORMATION

The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview and record review, the facility failed to post the daily nurse staffing information in a visible location on 3 of 4 days of the survey.

Findings included:

Observations on 08/10/15 at 11:00 AM and 4:30 PM, 08/11/15 at 8:30 AM and 4:30 PM and 08/12/15 at 8:00 AM and 3:00 PM revealed the daily nurse staffing information was not posted anywhere in the facility.

During an interview on 08/12/15 8:45 AM with the Director of Nursing (DON), the DON indicated the daily nurse staffing information was posted at the nursing station. However, the DON was unable to locate the staffing information at the nursing station.

In an interview with Human Resources Director on 8/12/2015 at 10:00 AM, the Director revealed the facility ' s nurse staffing information used to be posted, but the residents took it down, so it was now kept at the nursing station. An observation revealed the daily nurse staffing information was in a notebook at the nursing station and not visible to residents or visitors.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345447	A. BUILDING: ______ B. WING ______	8/13/2015

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 356	Continued From Page 1 During an interview with the Administrator on 8/12/15 at 11:30 AM, the Administrator reported the daily nurse staffing information should be posted in a visible location.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2015
FORM APPROVED
OMB NO. 0938-0391

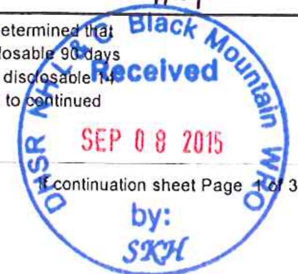
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345447	A. BUILDING ______ B. WING ______	C 08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD RIDGE REHAB AND CARE CENTER	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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation. Event ID# G82I11	F 000	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.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and medical	F 278	1.) It is the practice of the facility to accurately assess a resident's dental needs on the Minimum Data Set (MDS) assessment upon admission, quarterly and with a significant change in resident condition. On 9/2/15, the Minimum Data Set (MDS) Coordinator completed a significant correction to Resident #84's 3/28/15 MDS assessment to modify section "L" to reflect the residents' current, accurate dental condition of obvious broken natural teeth. The MDS Coordinator also completed the Care Area Assessments (CAA) that addresses the underlying causes, contributing factors, and risk factors from the comprehensive Minimum Data Set (MDS) assessment and corresponding dental care plan on 9/2/15 to ensure the residents' dental care needs are being met. Resident #84 continues at baseline on a pureed diet with no adverse effects or events.	09/10/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	9/5/15

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.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD RIDGE REHAB AND CARE CENTER	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 278	Continued From page 1 record review, the facility failed to accurately assess a resident's dental needs on the admission, a significant change and 2 quarterly assessments for 1 of 1 resident. (Resident #84). Findings included: Resident #84 was admitted to the facility on 11/14/14 with diagnoses of moderate to severe dementia, chronic kidney disease, history of cerebrovascular accident and hypertension. Review of the Minimum Data Set admission assessment completed on 11/21/14 revealed Resident #84 was cognitively impaired and unable to be interviewed. Resident #84 required extensive assistance with 2 person assist for personal hygiene, including oral care. There were no dental concerns noted on this assessment. Review of the significant change MDS dated 3/28/15 noted no dental concerns, review of the quarterly MDS dated 05/09/15 noted "mouth or facial pain, discomfort or difficulty with chewing" and the quarterly MDS dated 7/31/15 noted no dental concerns. During an observation on 08/12/2015 at 3:52PM, Resident #84 was noted to only have 4 teeth in the front of the lower jaw and approximately 5-6 teeth broken at the gum line of the upper jaw. Review of physician progress note dated 05/01/2015 revealed in his assessment that resident had sore mouth, very poor dentition, mild pain, evidence of inflammation of the gums with gingivitis and plaque buildup. On 08/13/15 at 8:08AM Resident #84 was seated for breakfast in the restorative dining room. Upon observation, a pureed diet was listed on the tray card for this resident. She was observed being fed by staff and was not in any discomfort with chewing. Phone interview with the Medical Director on 08/13/15 at 8:38AM revealed that resident had	F 278	2.) All facility residents are at risk of the alleged deficient practice. The MDS coordinators completed a 100% audit on 8/31/15 of the most recent comprehensive MDS assessment and compared that to the most recent nursing data collection assessment to validate the residents accurate dental status. Any discrepancies identified will have a significant correction on their most recent comprehensive MDS assessment and corresponding dental care plan completed by the MDS coordinator by 9/4/15. 3.) On 8/26/15, the Regional Case Mix/MDS Coordinator reeducated the facility MDS coordinators regarding accurate completion of the residents dental assessment (section L) on the admission, quarterly and significant change comprehensive MDS assessment. Newly hired MDS coordinators will be educated upon hire. Beginning on 9/2 and completed on 9/9/15, the Director of Clinical Services (DCS) reeducated licensed nurses on the accurate completion of the resident's data collection assessment on admission, quarterly and with significant change in residents condition which address the residents dental status. Licensed	09/10/2015

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F 278	Continued From page 2 severe cardiomyopathy and he would not recommend oral surgery due to her high risk of infectious complications. On 08/13/15 at 12:01PM an interview was conducted with the MDS Coordinator # 1. She reviewed the initial and latest 3 MDS assessments and stated that it was an oversight that the MDS had not been coded correctly and a care plan for dental/oral care had not been developed. On 08/13/15, a discussion with the Administrator and Director of Nursing (DON) of care areas reviewed, including dental/oral assessment, revealed the DON would involve the MDS Coordinator in morning rounds/meetings to develop more accurate assessments of care areas.	F 278	nurses were further reeducated by the DCS to complete a dental care plan on admission if poor dentition is identified. Newly hired licensed nurses will be educated upon hire. The MDS coordinator will review the licensed nurses' data collection assessment in coordination to completing the comprehensive MDS assessment on admission, annually, quarterly and with significant change in residents condition to validate accuracy when completing the dental assessment (section L). 4.) The DCS will audit admission, annual and significant change comprehensive MDS assessments to validate accuracy of the residents dental status (section L) daily for month, weekly for 2 months then, monthly for 3 months. The Director of Clinical Services will report audit results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	09/10/2015