STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	C 09/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE ON THE MOUNTAIN	417 CLOVERDALE ROAD SYLVA, NC 28779

(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 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to implement planned interventions of a wheelchair alarm to alert staff the resident was transferring without assistance for 1 of 3 residents reviewed for accidents. (Resident #3). Findings included: Resident #3 was admitted to the facility on	F 323	1. On 9/27/2017 a complaint survey was conducted by DHEC. During the investigation Resident #3 was observed sitting in a wheelchair with a chair alarm that was not functioning. This was observed numerous times by the survey team. Resident #3 receives 2 or more high fall risk medications. Resident #3 was admitted on 9/12/2017 with a diagnosis of Parkinson's disease and	10/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/19/2017

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F 323	Continued From page 1 09/12/17 with the diagnoses of Parkinson's disease and vascular dementia with behavioral disturbances. Review of the admission nursing note dated 09/12/17 indicated Resident #3 was alert and oriented to self, had adequate hearing and vision, and lower extremity swelling. A fall risk assessment dated 09/12/17 revealed Resident #3 received 2 or more high fall risk medications, had a unsteady gait, cognitive limitations, and was identified as a high fall risk. A nurse note dated 09/13/17 revealed Resident #3 was alert with periods of confusion with wandering behaviors and needed 2 person assistance with daily care. Review of an incident report on 09/14/17 at 12:25 PM revealed Resident #3 was sitting in a wheelchair eating when staff witnessed a fall in the dining room. The incident report indicated there was no injury and Resident #3 had full range of motion. The intervention put into place was a wheelchair pressure alarm. A review of the care plan dated 09/26/17 focused on falls and included nursing interventions to apply a wheelchair pressure alarm. The goal was for Resident #3 to remain free from injury. During an observation at 8:55 AM on 09/27/17, Resident #3 was sitting in a wheelchair with a pressure alarm placed in the seat that was disconnected from the battery box with the connecting cord hanging down behind the back of the seat.	F 323	vascular dementia with behavioral disturbances. Staff interviews revealed wheelchair pressure alarm was placed to help prevent falls. 2. Resident #3 continues to have a wheelchair alarm in place to help prevent falls. Resident #3's wheelchair alarm was reconnected to the battery box and verified that it was functioning properly on 9/27/17. 3. An audit was conducted by the Director of Nursing for all residents with alarms. A root cause analysis was conducted and the results of the findings were used to correct systems in place to insure that alarms are functioning per the care plans. Staff education was provided by the Director of Nursing. The initial in-service was conducted on 9/27/17 on each shift. An additional in-service was conducted on 10/16 – 10/17 and is on-going. In-services included fall prevention, use of bed/chair alarms, expectations of checking positioning and functioning of alarms, assessing wire connections at various times throughout the day. Checking batteries in alarm daily when resident is getting up or going to bed. Report any issues with alarms immediately to your supervisor. 4. The Director of Nursing will conduct random audits 3 times a week for 1 month, then 2 times a week for two months. 5. The results of the audits conducted by the Director of Nursing will be reported monthly to the QAPI committee and the findings will be used to identify system failures and corrective action needed to	

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F 323	Continued From page 2 During an observation made at 10:11 AM on 09/27/17, Resident #3 was observed in the hallway resting in a wheelchair with a pressure alarm unattached from the battery box and the connecting cord hanging off to the side of the wheelchair. During an observation made at 10:49 AM on 09/27/17, Resident #3 was observed sitting in a wheelchair with a pressure alarm that was disconnected from the battery box with the connecting cord hanging down behind the back of the seat. Resident #3 was at an activity of ball toss with other residents in the dining room and was alert and looking around. During an observation made at 11:15 AM on 09/27/17, Resident #3 was observed sitting in a wheelchair with a pressure alarm that was disconnected from the battery box with the connecting cord hanging down behind the back of the seat. Nurse #1 was observed pushing Resident #3 through the dining room into the hallway towards the nurses' station. During an interview at 1:26PM on 09/27/17, NA #1 revealed sometimes Resident #3 didn't seem to know what was going on and at times would try to get out of the wheelchair without assistance and was able to self-propel when sitting in the wheelchair. NA #1 also revealed a wheelchair pressure alarm was placed to help prevent falls. During an interview at 3:34 PM on 09/27/17, Nurse #1 confirmed Resident #3 was alert and had attempted to get up without assistance and a pressure alarm was placed to alert staff when Resident #3 was trying to get out of the wheelchair.	F 323	prevent alarms from not functioning properly. 6. The Administrator will be responsible for insuring the processes, audits and action plans are implemented.	

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F 323	Continued From page 3 During an interview at 4:22 PM on 09/27/17, the Director of Nursing revealed the expectations were for wheelchair alarms to be connected and working when placed as interventions to prevent falls and those expectations were not being met.	F 323		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to clean 1 of 1 ice machine in the kitchen and 2 of 2 nourishment room refrigerators	F 371	1. On 9/27/2017 a complaint investigation was conducted. Based on the observations and staff interviews the	10/17/17

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F 371	Continued From page 4 (300 and 100 halls). The findings included: 1. a. An observation was conducted of the ice machine in the kitchen on 09/27/17 at 4:14 PM. The Dietary Manager (DM) was present for the observation. A black colored substance was observed inside the ice machine on the box over the evaporator that makes the ice. The DM was able to wipe the substance off with a paper towel. This substance had no direct contact with the ice or water used to make the ice. The DM had been working in the facility for approximately 5-6 weeks and was uncertain who had the responsibility of cleaning the ice machine. An interview with the Maintenance Director on 09/27/17 at 4:29 PM revealed he had been working for the facility approximately 5 weeks. He observed the black substance on the box over the evaporator and explained it was the maintenance department's responsibility to clean the ice machine once a month. This cleaning involved removing the top of the machine so all the inside mechanisms could be taken apart and thoroughly cleaned. He stated he had not done that cleaning for the month of September. The Maintenance Director added he just found out cleaning the ice machine was the maintenance department's responsibility. b. An observation of the refrigerator in the 100 hall nourishment room was conducted 09/27/17 at 4:35 PM. Stains that appeared to be spilled liquids and smudges of food were observed on the refrigerator door and the door handle. Splatters of what appeared to be juice were observed on the bottom shelf inside the	F 371	facility failed to maintain the ice machine and nourishment refrigerators in a clean and sanitary condition. Interviews with the Dietary Manager and Maintenance Director revealed that neither of them understood who was responsible for the cleaning of ice machine and refrigerators. The ice machine had a black colored substance and the refrigerators had what appeared to be spilled dried liquids, smudges of food, discolored with a blackish material and one of the freezers had a paper residue and what appeared to be dust. 2. The ice machine was cleaned by the Maintenance Director on 9/27/17 and the refrigerators were cleaned by the Dietary Manager on 9/28/17. 3. Maintaining the cleanliness of the ice machine has been assigned to the Maintenance Director. The ice machine monthly cleaning schedule has been added to the TELS maintenance system. The Dietary Manager has been assigned the responsibility for cleaning the nourishment room refrigerators. 4. The Dietary Manager will clean the refrigerators at least 3 times a week for 1 month, then once a week for 1 month then monthly and log the results on the audit log. The Administrator will monitor the cleanliness of the refrigerators after a cleaning has been performed to insure they are being maintained in a clean and sanitary condition. The Maintenance Director will clean the	

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F 371	Continued From page 5 refrigerator. At 4:38 PM on 09/27/17 the 300 hall nourishment room refrigerator was observed. The freezer section contained paper residue at the base of the freezer shelf and what appeared to be dust. The refrigerator door handle was discolored with a blackish material and spills of liquids were noted around the door handle extending down to the bottom of the refrigerator door. An interview with the Director of Nursing at 4:40 PM on 09/27/17 revealed the DM was responsible for keeping the nourishment room refrigerators clean. At 4:42 PM on 09/27/17 observations of both refrigerators were made with the DM. She stated she was unaware the dietary department was responsible for ensuring these refrigerators were clean. An interview with the Administrator on 09/27/17 at 6:50 PM revealed he expected ice machines and nourishment room refrigerators to be kept clean. He stated he it was his responsibility to communicate with the department heads so they understood their duties.	F 371	ice machine weekly for 1 month, then twice a month for 1 month, then monthly to maintain the ice machine is in a clean and sanitary condition.The Administrator will monitor the cleanliness of the ice machine a cleaning has been performed to insure they are being maintained properly. 5. The results of the audits performed by the Dietary Manager and Maintenance Director will be reported monthly to the QAPI committee and the findings will be used to identify system failures and corrective action needed to prevent further incidents. This will be on-going as part of the QAPI meetings. The QAPI committee will monitor these issues monthly for at least three months. 6. The Administrator will be responsible for insuring the processes, audits and action plans are implemented.	