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 12/06/2021

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 An unannounced onsite complaint investigation was conducted on 11/30/21. Additional information was obtained through 12/06/21. Therefore, the exit date was changed to 12/06/21. 1 of the 1 allegation was substantiated and cited. Past-noncompliance was identified at: CFR. 483.25 at tag F689 at a scope and severity (J) Tag F 689 constituted Substandard Quality of Care. Non-compliance began on 11/22/21. The facility came back in to compliance effective 11/25/21. A partial extended survey was conducted on 12/06/21.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to supervise a severely cognitively impaired resident with wandering behaviors from exiting the facility unsupervised while self-propelling in her wheelchair. On 11/22/21 all	F 689	Past noncompliance: no plan of correction required.	12/21/21

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

Electronically Signed | 12/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 1	F 689		

three staff members working the evening shift left the hall without communicating with each other and as a result they did not respond to the door alarm or initiate an immediate search. As a result, Resident #1 was able to exit through the fire/exit door which opens once the handle is pushed on for 15 seconds. This resulted in Resident #1 falling out of her wheelchair, hitting her head on the sidewalk and sustaining an open fracture to her left thumb. This failure affected 1 of 3 residents reviewed for providing supervision to prevent accidents.

The findings included:

Resident #1 was admitted into the facility on 02/02/21 with diagnosis which included unsteadiness on feet, muscle weakness, history of falling, and non-Alzheimer's dementia.

Resident #1's admission history and physical dated 02/09/21 revealed she had a history of wandering behavior and exit seeking, the note revealed she was sent to the facility because of the need for a locked unit.

Resident #1's elopement risk evaluation dated 02/09/21 revealed she was determined to be at risk for elopement.

Resident #1's quarterly Minimum Data Set (MDS) dated 10/16/21 revealed she was severely cognitively impaired. She was coded as having no episodes of wandering during the assessment period. Resident #1's mobility device was coded as a wheelchair.

Resident #1's care plan dated 11/01/21 revealed a focus area for elopement and wandering in the

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F 689	Continued From page 2	F 689		

facility. The goal was for Resident #1 to not leave the facility unattended through the next review date. Interventions included distraction from wandering, a wander guard, monitoring for fatigue and providing structured activities.

Review of Resident #1's Medication Administration Record (MAR) dated November 2021 revealed an order for wander guard placement. The order stated to check for function each day and night shift for monitoring. On 11/22/21 the day shift nurse had initialed Resident #1's wander guard was in place and functioning. The night shift documentation was left blank due to the resident being sent to the hospital for an evaluation.

A fall report dated 11/23/21 by the Assistant Director of Nursing (ADON) revealed Resident #1 had an unwitnessed fall outside of the building on the facility premises on 11/22/21. It was documented Resident #1 was wandering aimlessly at the time of the event. The injury was described as a major injury due to a thumb fracture with bone exposed. Resident #1 was transported to the hospital for an evaluation.

The weather report for 11/22/21 at 8:00 PM revealed the temperature was 33 degrees outside in Asheville, North Carolina. (Asheville, NC Monthly Weather Forecast- weather.com, 2021).

On 11/30/21 at 11:45 AM an interview was conducted with (MA) #1. She stated she was working the 7:00 to 11:00 PM shift on 11/22/21. The interview revealed she had started her medication pass on the hall when she noticed another resident needed to be assessed by a nurse. She stated she yelled for NA #1 and told

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
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F 689	Continued From page 3	F 689		

her she needed to go get Nurse #1 because that was facility policy. She stated she left the memory care unit to get Nurse #1. When they returned the exit, door was alarming, but she and Nurse #1 did not disable the alarm. They went into the male resident's room to assess him. She stated when they were finished NA #2 had returned to the memory care unit from another hall and she asked him to disable the door alarm. She stated they checked all the resident rooms and realized Resident #1 was missing. The interview revealed NA #2 went outside to look for Resident #1 while she remained on the hall with the other residents because they could not find NA #1. She stated when they returned with the resident from outside, she came in with a blood all over her face and she stated she could see the residents bone coming from her left thumb. MA #1 stated she called EMS and they entered the building quickly after. She stated earlier in the shift Resident #1 was in her wheelchair rolling up and down the hall. She stated when she came out and the door was alarming. MA #1 stated nobody was on the resident hall when she went from the unit to get Nurse #1 because NA #1 had not told her she was leaving the unit. She stated when she went into the male resident's room it was 7:50 PM and when she called EMS for Resident #1 it was 8:05 PM.

On 11/30/21 at 2:45 PM an interview was conducted with Nurse Aide (NA) #2. He stated he was working the 3:00 PM to 11:00 PM shift on 11/22/21. NA #2 stated he had stepped off the memory care locked unit to go assist another NA on a resident hall. The interview revealed he heard an alarm sounding from outside of the memory care unit, so he typed in the code and went through the doors onto the unit. He stated

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F 689	Continued From page 4	F 689		

once on the hall, Medication Aide #1 asked him how to turn the door alarm off because she didn't know the code and also asked where NA #1 was because she wasn't on the hall. NA #2 then turned the door alarm off and MA #1 stated she couldn't find Resident #1. NA #2 stated they began to look in the resident rooms and he told MA #1 he couldn't find Resident #1. He then went to the nurse's station and put on his coat before going outside of the building through the front door to look for Resident #1. He stated he found Resident #1 lyying in between two vehicles right off the curb to the parking lot from the fire/exit door to the memory care unit. NA #2 stated Resident #1 was approximately 15 feet from the door going to the parking lot. He stated Resident #1's wheelchair was upside down and she was lying on her left side on the pavement right off the sidewalk curb. NA #2 stated Resident #1's face was covered with a blood coming from her eyebrow area. He then asked NA #1 who was coming out the fire/exit door of the unit to stay with the resident while he went to get the Assistant Director of Nursing (ADON). The interview revealed NA #2, NA#1 and the ADON brought the resident back into the facility to assess her. He stated it was then he saw her thumb with the skin peeled back exposing her bone. He stated MA #1 called Emergency Medical Services (EMS) and they entered the building shortly after. The interview revealed Resident #1 had been constantly at the fire/exit door on the night of 11/22/21. He stated him, NA #1 and MA #1 had seen her at the door, and he had placed her into the day room prior to leaving the hall to go help another NA. NA #2 stated Resident #1's wander guard was in place, but the anklet would not work on the memory care unit doors. NA #2 stated staff members were keeping a closer eye

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	345447	A. BUILDING _____ B. WING _____	C 12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 5	F 689		

on Resident #1 since the incident and were making sure a staff member was always present on the hall.

An interview conducted with NA #1 on 11/30/21 at 11:12 AM revealed she was working during second shift on 11/22/21 caring for Resident #1. NA #1 stated she had seen the resident going up and down the hall in her wheelchair during the shift. She stated she had gone off of the memory care unit to the restroom around 8:30 PM and did not remember telling anyone. When NA #1 came back on the memory care unit NA #2 and Medication Aide (MA) #1 were looking for Resident #1. The alarm on the door was not going off when she came back onto the unit. She stated they were looking in the resident rooms and she went through the exit/fire door outside while NA #2 went around the front of the building through another door to the outside. She stated Resident #1 was directly outside of the door going to the parking lot. Resident #1 had run off the curb, flipped her wheelchair and was lying on the pavement with the left side of her face on the pavement. NA #1 stated there was a pool of blood under the resident. She stated NA #2 came around the front just as she did, and he went back to get the Assistant Director of Nursing (ADON) who then came outside and helped assist Resident #1 into her wheelchair. Once they got Resident #1 inside of the building, she was placed in her bed so the ADON could assess her, and the Medication Aide called 911. She stated Emergency Medical Services (EMS) came quickly after they were called and took the resident to the hospital. NA #1 stated Resident #1 seemed to be in shock after the incident happened not crying or stating she was in any pain. She stated the resident was wearing a short sleeve gown. NA #1

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 12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 6	F 689		

stated Resident #1 had pushed on the door until she was able to get out. NA #1 explained if you pushed on the exit/fire door handle for 15 seconds the door would release and open.

On 11/30/21 at 2:01 PM an interview was conducted with Nurse #1. She stated MA #1 had come onto her hall and asked her to assess a male resident on the memory care unit. She stated she went onto the unit with MA #1 assessed the resident and returned to her hall.

Review of hospital records dated 11/22/21 revealed Resident #1 had eloped from a memory care unit in a wheelchair, fell out of the wheelchair hitting her head on the sidewalk and sustained an open fracture to her left thumb. The computed tomography (CT) scan of Resident #1's face showed right facial soft tissue swelling. The CT of Resident #1's head showed right periorbital (swelling around the eyes) soft tissue swelling.

Review of a nursing progress note dated 11/23/21 at 6:31 AM revealed Resident #1 had returned from the hospital at approximately 2:18 AM following a fall with injury. The note stated report was received from the hospital nurse stating the resident had an abrasion to her chin, fractured/displaced left thumb, abrasion to her left middle finger, skin tear to the knuckle of the third finger, periorbital bruising of the right eye, laceration above the right eyebrow and busted lip. She also had an abrasion noted to her right knee. Her head scans were normal, and the resident returned to the facility with an order for Keflex (antibiotic) 500 milligrams by mouth three times a day to prevent an infection.

A Physician progress note dated 11/23/21

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 12/06/2021

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

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F 689	Continued From page 7	F 689		

revealed Resident #1 was evaluated on this date. The note revealed Resident #1 had experienced a fall with a head injury and to continue closely monitoring her. Resident #1 was to follow up with an orthopedic surgeon for an open fracture to her left thumb. The documentation revealed Resident #1 was at her baseline mental status during the evaluation. Resident #1 had received a laceration to her right eyebrow from the fall and an antibiotic was initiated.

An observation conducted on 11/30/21 at 10:01 AM on the memory care unit of the facility. The surveyor pushed on exit/fire door handle for 15 seconds and the door alarm sounded as the door opened. NA #3 responded to the door quickly.

An interview conducted on 11/30/21 at 10:10 AM with NA #3 revealed if you pushed on the exit/fire door handle for 15 seconds it will open.

On 11/30/21 at 1:49 PM an interview was conducted with the ADON. She stated she was in her office at the front of the building on 11/22/21 when around 8:00 PM NA #2 came in her office and stated Resident #1 was lying in the parking lot and NA #1 was with the resident. She stated when she went outside Resident #1 was lying on her left side on the pavement in between two cars in the parking lot. Her wheelchair had fallen from the curb. Resident #1 had sustained a laceration to her eye. She stated since it was cold, and the resident only had on a short sleeve gown they placed her in her wheelchair and took her inside to assess her. She stated there was blood coming from her laceration to her face and she could see the resident's bone in her thumb. The ADON stated she had heard an alarm going off prior to the incident but thought it could have

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 12/06/2021

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

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F 689	Continued From page 8	F 689		

been from the dining room. She stated after EMS transported the resident to the hospital she immediately began in-servicing staff about making sure a staff member was always present on the hall, to let someone know if they were going off the hall and to promptly respond to door alarms. She stated she obtained statements from the staff who were involved. She stated she had also conducted a head count of everyone who was in the building and completed a fall report. The ADON stated Resident #1 was wearing a wander guard at the time of the incident.

On 11/30/21 at 12:00 PM an interview was conducted with the Administrator. He stated the ADON had conducted an in-service for all staff on monitoring the doors daily and being present on the hallway at all times. He stated the doors were checked daily for functionality. The interview revealed they had been trying to order an alarming mat to place in front of the door and the order was placed on 11/23/21. The interview revealed the wander guard anklets only worked on the front door to the facility and not on the doors leading from the memory care unit.

On 11/30/21 at 1:35 PM an interview was conducted with the Administrator, The Regional Director of Clinical Services, and the Director of Nursing. During the interview The Regional Director of Clinical Services stated he had spoken with the Corporate Safety Advisor on 11/23/21 regarding the locking system on the facility doors. He stated they had discussed changing the door system to disable the paddle bar from allowing the door to open. The interview revealed there would be a keypad placed with a cover and alarming system 5 feet from the door. The interview revealed a staff member from another

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 12/06/2021

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F 689	Continued From page 9	F 689		

facility was scheduled to come on 11/30/21 to assess the system with an electrician to see how they could change it, so the door did not open after 15 seconds to better secure the memory care unit. The interview revealed a in-service was initiated on 11/22/21 for all nursing staff on being present on the hallway, notifying co-workers prior to leaving the unit and to promptly respond to door alarms. A Performance Improvement Plan (PIP) guide was put into place on 11/24/21 to improve security for the exterior door on the memory care unit. The root cause for the issue was documented as residents wandering continually on A hall including in the area near the door and requiring constant redirection. The staff were occupied and did not hear the warning buzzer. The solution included adding a switch to the door to disable the push bar. A stop sign was placed on the fire/exit door by the ADON on 11/22/21.

The facility provided the following Corrective Action Plan with the correction date of 11/25/21:

At time of incident on 11/22/2021 immediate medical intervention was provided to ensure Resident #1's safety, including having resident transferred to the hospital for evaluation and treatment. Resident #1 returned from the hospital on 11/23/21 and was evaluated by Nurse Practitioner that day at our facility to ensure that her medical needs were being met. No new orders were noted by the Nurse Practitioner.

On 11/22/2021 after Resident #1 was transferred to the hospital the Assistant Director of Nursing checked the A hall exterior door and found it to be functioning properly. A head count was immediately conducted of all residents in the

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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

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F 689	Continued From page 10	F 689		

building to ensure that no other residents were at risk. Assistant Director of Nursing immediately began educating all present staff on facility elopement protocols, staffing policies to ensure staff do not leave the unit unattended at any time, to notify team members on the hall with them when they are taking a break and monitoring of exterior exits to include responding immediately to fire/exit door alarms. Assistant Director of Nursing also reviewed resident elopement risk assessments for all residents on A hall and verified the elopement book was up to date and current with current resident elopement list. Additionally, a velcro-release STOP sign was placed on the door.

On 11/23/21 immediately upon arriving the Director of Nursing checked the door on A hall to ensure that it was functioning properly and found it to be functioning as designed. On 11/23/2021 the facility's Maintenance Director examined all exterior doors in the facility to ensure they were functioning properly and found all exterior doors to be functioning as designed. An informal nursing staff meeting was called by the Director of Nursing at the nurse's station to speak with all available staff members to provide education on facility elopement protocols, staffing policies to ensure staff do not leave the unit unattended at any time, to notify team members on the hall with them when they are taking a break and monitoring of exterior exits to include responding immediately to fire/exit door alarms.

On 11/23/2021 a performance improvement plan was developed to find ways to improve safety of residents and adherence of staff and elopement prevention policies. An ad hoc quality assurance performance improvement meeting was held with

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F 689	Continued From page 11	F 689		

the interdisciplinary team members setting goals and actions to address the incident and ensure resident safety moving forward. The formal investigation into the event was started. A root cause was determined on 11/23/2021 that staff did not respond to the warning buzzer on the A hall fire/exit door timely due to all three staff members not being on the hall when the fire/exit door sounded and resident #1 exited the building.

On 11/23/2021 the Director of Nursing provided education to the 2 unit managers on policy not leave any hall unattended at any time, to notify team members on the hall with them when they are taking a break as well as elopement prevention policy and procedures. On 11/23/2021 the Director of Nursing, Assistant Director of Nursing and the 2 unit managers continued educating staff prior to working their next scheduled shift on policy to not leave any hall unattended at any time, to notify team members on the hall with them when they are taking a break as well as elopement prevention policy and procedures. Education was completed for all current staff by 11/24/2021 with the exception of a few prn staff have not received education but will not be allowed to work until trained. Newly hired staff will be trained prior to working. The Director of Nursing will ensure completion of training.

On 11/23/21 a Quality Monitoring tool was started by the Director of Nursing to be signed off by the Director of Nursing, Assistant Director of Nursing, and 2 Unit Managers to ensure staffing for A hall, that staff are on the unit and that staff understand not to leave the unit unless they have let the other staff members on the unit know. On 11/23/2021 the Director of Nursing also trained the Assistance Director of Nursing and 2 Unit

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	345447	A. BUILDING _____ B. WING _____	C 12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 689	Continued From page 12	F 689		

Managers on the process and responsibility of the audit tool. The audit tool will be completed on 2 shifts daily to include all shifts (7am-7pm, 7pm-7am x 7 days), then every other day x 7 days, then every 3rd day for 7 days, then weekly. The results will be reviewed in monthly QAPI with the interdisciplinary team members.

The Facility alleges compliance on 11/25/2021.

The Corrective Action Plan was validated on 12/06/21 and concluded the facility implemented an acceptable corrective action plan on 11/25/21. The facility created a performance improvement plan to find ways to improve safety of residents and adherence of staff and elopement prevention policies. An ad hoc quality assurance performance improvement meeting was held with the interdisciplinary team members setting goals and actions to address the incident and ensure resident safety moving forward.

The weekly monitoring logs to ensure that staff are on the A unit and understand not to leave the unit unless they have let the other staff members on the unit know were reviewed from November 2021 to December 2021 with no concerns identified. Review of the nursing staff in-service sheets on facility elopement protocols, staffing policies to ensure staff do not leave the unit unattended at any time, to notify team members on the hall with them when they are taking a break and monitoring of exterior exits to include responding immediately to fire/exit door alarms training revealed the nursing staff had initialed as receiving the in-service training. Interviews conducted with nursing staff from first, second and third shifts revealed they had received the in-service as stated by the facility. The staff

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 12/06/2021

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 689	Continued From page 13 verified they had received in-servicing on facility elopement protocols, staffing policies to ensure staff do not leave the unit unattended at any time, to notify team members on the hall with them when they are taking a break and monitoring of exterior exits to include responding immediately to fire/exit door alarms.	F 689		