STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345447	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Ridge Health and Rehabilitation	**25 Reynolds Mountain Boulevard , Asheville, North Carolina, 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
F0000	INITIAL COMMENTS A complaint investigation was conducted from 11/06/25 to 11/07/25. Event ID#1DAD4F-H1. The following intake was investigated: 2655146. 1 of the 1 complaint allegations did not result in a deficiency.	F0000		11/26/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F0641	The following Plan of Correction (PoC) is submitted in response to the Centers for Medicare & Medicaid Services (CMS) Form 2567 Statement of Deficiencies. This PoC is provided solely for the purpose of addressing the specific findings cited by CMS surveyors. This submission does not constitute, nor should it be construed as, an admission of wrongdoing, liability, or deficiency by the facility, its staff, or its management. The corrective actions described herein are intended to demonstrate the facility's commitment to compliance with applicable regulations and to ensure the health, safety, and well being of all residents/patients. Implementation of the corrective measures outlined in this PoC is undertaken in good faith and for regulatory compliance purposes only. Resident #1's MDS assessment was updated to accurately reflect the resident's behaviors, wandering and wander guard placement by the Minimum Data Set Nurse on 11/07/2025. On 11/08/2025 through 11/14/2025 the MDS Nurses performed quality improvement monitoring of the last 30 days of MDS assessments for accurately coding behaviors, wandering and placement of wander guard(s). Any issues identified were addressed. The Minimum Data Set Nurse was re-educated by the Executive Director on accurate coding of the MDS on 11/24 /2025. Newly hired MDS nurses will be educated upon hire.	11/26/2025

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 reverse for further 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.

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

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F0641 SS = D	Continued from page 1 §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, the facility failed to complete an accurate Minimum Data Set (MDS) in the areas of behaviors, wandering, and the use of a wanderguard bracelet (used to protect residents from elopement) for 1 of 2 residents review for accuracy of assessments (Resident #1). The findings included: Resident #1 was admitted to the facility on 10/23/25 with diagnoses of cerebral infarction (stroke), cognitive communication deficient and unspecified symptoms and signs involving cognitive functions and awareness. On 10/29/25 the Medical Director added the diagnosis adjustment reaction with aggression. The admission Assessment dated 10/23/25 indicated that Resident #1's mood was described as combative with staff, and his behavior was physically abusive. On 10/26/25 a behavioral note indicated that Resident #1 was exit seeking and unable to be redirected. He was striking staff and knocked over a water dispenser. Resident #1 had been up all night wandering the unit searching for exits. The on-call psychiatry provider was notified. The on-call psychiatrist ordered hydroxyzine (antihistamine) 50 milligrams (mg) every 6 hours as needed and trazodone (antidepressant) 50 mg to be given at night. He also ordered a wanderguard bracelet (used to protect residents from elopement) to be applied to the left ankle. On 10/26/25 an "alert note" indicated a Nurse Aide (NA) was summoned to a room via call bell and yelling. When the NA arrived, she saw Resident #1 standing by his roommate's bed with a broken wooden hanger in his hand and the roommate had facial injuries. Resident #1 was quickly assigned 1 on 1 and continued to be combative to the staff person assigned. Resident #1 was walking around the hall and urinated on the floor and continued to be combative. After several minutes Resident #1 was willing to lay down in his bed and rest. There were no further behaviors and 1 on 1 continued. The 10/29/25 Initial History and Physical completed by the facility's Medical Director indicated that Resident #1 had ongoing cognitive deficit and he demonstrated some elopement behaviors upon admission to the	F0641	Continued from page 1 Starting on 11/17/2023 The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement Monitoring of the MDS's for accurately coding of behaviors, wandering and placement of wander guard(s) three times per week for 4 weeks the weekly for 8 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/25/2023. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Alleged Compliance Date: 11/26/2025.	

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F0641 SS = D	Continued from page 2 facility. On 10/26/25 Resident #1 was found to be next to his roommate with a broken wooden hanger and roommate had trauma to his face. This was an unwitnessed incident and Resident #1 was placed on 1 on 1 supervision. There had not been any more aggressive behaviors since but Resident #1 will get agitated. The 5-day admission Minimum Data Set (MDS) dated 10/29/25 revealed that Resident #1 was cognitively intact, had no behaviors and no wanderguard. On 11/6/25 at 5:04 PM an interview was held with the Social Worker Manager. The Social Worker Manager stated that he did not indicate Resident #1 had a behavior of wandering because Resident #1 had a purpose to why he had been trying to exit the facility. Resident #1 stated he wanted to go home. The Social Worker Manger stated that if the resident was trying to exit the facility and had no purpose then he would indicate wandering on the MDS. The Social Worker Manager stated that he did not indicate any behavioral issues because the incident happened after he had completed his part of the MDS, which was on 10/24/25. On 11/7/25 at 9:59 AM an interview was conducted with the MDS Nurse. She stated the look back period for the 5-day admission MDS for Resident #1 was from 10/23/25 through 10/29/25. She stated that if a staff person enters information into the MDS and something changes during the look back period the staff person would need to go into the MDS and make the changes. Since Resident #1 had been exiting seeking the MDS should have been marked as a “yes” to wandering. The MDS Nurse was unsure why the Social Worker Manager did not make this change. Also since there was documentation of Resident #1 being both verbal and physically agitated towards staff and other residents during the look back period the Social Worker Manager should have reflected that by answering "yes". The MDS Nurse did not know why the Social Worker Manager did not go back and make changes to the MDS. The MDS Nurse stated that she would make changes to the MDS by marking "yes" for the wanderguard and for both verbal and physical behaviors. On 11/7/25 at 10:53 AM there was an interview held with the Administrator. She stated she had been ill during the time of the MDS assessment for Resident #1 and felt if she had been at the facility the MDS would have been completed correctly because she would have reviewed the MDS.	F0641		