STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345048	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE WELLNESS CTR	315 OLD US HWY 70 EAST BLACK MOUNTAIN, NC 28711

(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 312 SS=E	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 observations, staff and resident interviews, and medical record review, the facility failed to trim and clean fingernails for one (1) of six (6) residents (Resident #18) and failed to remove facial hair for four (4) of six (6) residents (Residents #42, 30, 10 and 94). The findings are: 1. Resident #18 was admitted with diagnoses of congestive heart failure, dementia, and diabetes. The latest Minimum Data Set dated 12/13/11 revealed the resident had severe cognitive impairment and required extensive to total assistance with activities of daily living (ADL) including extensive assistance of one person for personal hygiene. The resident's care plan, revised 12/29/11, addressed the resident's need for assistance with ADL with an intervention to assist the resident with all ADL as needed. On 02/13/12 at 3:35 PM Resident #18 was observed in his wheelchair in the hallway. The resident was observed to have fingernails extending approximately 1/8 inch longer than his fingers. The nails were observed to be jagged with rough edges. The nail on the right index	F 312	The resident found to be affected by the deficient practice has been assessed with no negative outcome noted. This resident's nails were trimmed and cleaned immediately by the licensed charge nurse. No other resident's have been found to have been affected by this deficient practice. Staff in-serviced to cut and clean all non diabetic resident's fingernails on their assigned shower days and PRN. If resident is diabetic CNA's instructed to notify licensed charge nurse to cut and clean nails immediately. Quality Assurance Nurse will audit this 3x week for 3 months; then 1x week thereafter if compliance is accomplished. The Director of Nursing or RN Supervisor will be notified if concerns are noted and staff will be educated if problems have been identified. RECEIVED MAR 0 9 2012 BY:_____	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wayne Hall — TITLE: Administrator — (X6) DATE: 3-8-12

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 312	Continued From page 1 finger was partially broken off vertically approximately ¼ inch down, leaving a sharp corner. The right index finger and right center fingernails had brown matter beneath them. Resident #18's nails were observed again, in the same condition as above, on 02/14/12 at 9:00 AM and on 02/15/12 at 9:45 AM. On 12/15/12 at 1:43 PM Nursing Assistant (NA) #3 was interviewed. She stated that residents' fingernails were checked by staff on shower days twice a week, but that any time nails were long, jagged, or dirty they needed to be cleaned and trimmed right away. She stated that jagged nails could scratch a resident and that dirty nails were a hygiene issue. NA #3 examined Resident #18's fingernails and noted they needed cleaning and trimming. On 12/15/12 at 2:00 PM the facility Registered Nurse (RN) Supervisor was interviewed. She examined Resident #18's fingernails and noted they needed trimming and cleaning. She noted that the resident had a history of scratching himself and had open areas on his arms from scratching. The RN Supervisor stated she expected the NAs to check and address long, jagged, or dirty fingernails as part of their daily care. On 02/15/12 at 2:22 PM the Director of Nursing (DON) was interviewed. She stated she expected the NAs to check fingernail condition daily. She noted the resident did scratch himself a lot. The DON also noted that the resident was occasionally resistant to care but she had not been informed of any recent resistance to nail	F 312		

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F 312	Continued From page 2 care. 2. Resident #42 was admitted to the facility with diagnoses of paralysis agitans and dementia. The most recent Minimum Data Set dated 01/03/12 revealed the resident had moderate cognitive impairment and required extensive to total assistance with all activities of daily living (ADL) including extensive assistance of one person for personal hygiene. The resident's care plan, revised 01/12/12, addressed the resident's need for assistance with ADL with an intervention to assist the resident with all ADL as needed. On 02/14/12 at 9:53 AM Resident #42 was observed in her wheelchair in her room. She was observed to have approximately one dozen chin hairs approximately ¼ inch long. On 02/15/12 at 9:35 AM the resident was again observed in her room with the chin hairs as above. On 02/15/12 at 1:43 PM Nursing Assistant (NA) #3 was interviewed. She stated that residents' facial hair was checked by staff on shower days twice a week, but also checked by NAs as part of daily care. NA #3 stated she trimmed or plucked long facial hairs on female residents whenever she saw them. On 02/15/12 at 2:00 PM the facility Registered Nurse (RN) Supervisor was interviewed. She stated she expected NAs to check for and trim or pluck facial hair on female residents as part of their daily care. The RN Supervisor examined the chin hairs on Resident #42 and noted they were approximately ¼ long and should have been seen	F 312		

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F 312	Continued From page 3 and addressed by the NAs. On 02/15/12 at 2:22 PM the Director of Nursing was interviewed. She stated she expected NAs to check and trim or pluck facial hair on female residents as part of daily care. 3. Resident #30 was admitted to the facility with diagnoses of intracerebral hemorrhage and dementia. The most recent Minimum Data Set (MDS) dated 12/16/11 revealed the resident had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also revealed the resident required extensive to total assistance with all activities of daily living (ADL) including total assistance of one person for personal hygiene. The resident's care plan, revised 12/20/11, addressed the resident's need for assistance with ADL with an intervention to assist the resident with all ADL she was unable to perform independently. On 02/14/12 at 10:15 AM Resident #42 was observed in her gerichair in her room. She was observed to have approximately one half dozen chin hairs approximately ¼ inch long. On 02/15/12 at 9:30 AM the resident was again observed in her room with the chin hairs as above. On 02/15/12 at 1:43 PM Nursing Assistant (NA) #3 was interviewed. She stated that residents' facial hair was checked by staff on shower days twice a week, but also checked by NAs as part of daily care. NA #3 stated she trimmed or plucked long facial hairs on female residents whenever	F 312	Those resident's found to be affected by the deficient practice were assessed for negative outcome and no negative outcome was noted. Shave and or pluck facial hair of resident is assigned to a CNA on 1st or 2nd shift (see shower schedule) everyday regardless of that resident's shower. CNA's in-serviced to check all resident's (male or female) on that hall everyday and PRN for facial hair that needs to be removed and if facial hair is found, CNA is responsible for shaving and or plucking the facial hair. If the resident refuses to have facial hair removed such refusal must be made known to the MDS coordinator responsible for that resident and such refusal must be care planned. Quality Assurance Nurse will audit this 3x a week for 3 months; then 1x week thereafter if compliance is accomplished. .The Director of Nursing or RN Supervisor will be notified if concerns are noted and staff will be educated if problems have been identified.	03/15/12

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F 312	Continued From page 4 she saw them. On 02/15/12 at 2:00 PM the facility Registered Nurse (RN) Supervisor was interviewed. She stated she expected NAs to check for and trim or pluck facial hair on female residents as part of their daily care. The RN Supervisor examined the chin hairs on Resident #42 and noted they were approximately ¼ long and should have been seen and addressed by the NAs. On 02/15/12 at 2:22 PM the Director of Nursing was interviewed. She stated she expected NAs to check and trim or pluck facial hair on female residents as part of daily care. 4. Resident #10 was admitted to the facility with diagnoses of congestive heart failure and senility. The most recent Minimum Data Set (MDS) dated 12/09/11 revealed the resident was cognitively intact and required extensive assistance with all activities of daily living (ADL) including extensive assistance of one person for personal hygiene. The resident's care plan, revised 12/09/11, addressed the resident's need for assistance with ADL with an intervention to assist the resident with all ADL she was unable to perform independently. On 12/14/12 at 10:19 AM Resident #10 was observed on her bed in her room. She was observed to have chin hairs approximately ¼ inch long. On 02/15/12 at 9:36 AM the resident was again observed in her room with the chin hairs as above.	F 312		

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F 312	Continued From page 5 On 02/15/12 at 1:43 PM Nursing Assistant (NA) #3 was interviewed. She stated that residents' facial hair was checked by staff on shower days twice a week, but also checked by NAs as part of daily care. NA #3 stated she trimmed or plucked long facial hairs on female residents whenever she saw them. On 02/15/12 at 2:00 PM the facility Registered Nurse (RN) Supervisor was interviewed. She stated she expected NAs to check for and trim or pluck facial hair on female residents as part of their daily care. The RN Supervisor examined the chin hairs on Resident #42 and noted they were approximately ¼ long and should have been seen and addressed by the NAs. On 02/15/12 at 2:22 PM the Director of Nursing was interviewed. She stated she expected NAs to check and trim or pluck facial hair on female residents as part of daily care. 5. Resident #94 was admitted to the facility 08/14/09 with diagnoses that included hypertension, diabetes, dementia, and osteoporosis. Review of her most recent annual Minimum Data Set (MDS) dated 11/09/11 revealed she had moderate cognitive impairment. The MDS further revealed she needed extensive assistance of one person for personal hygiene. Resident #94's care plan revised 02/12/12 revealed she was at risk for further decline in activities of daily living related to lack of coordination and macular degeneration. The goal was to meet Resident #94's needs with staff assistance.	F 312		

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F 312	Continued From page 6 An observation was made on 02/13/12 at 12:51 PM of Resident #94 propelling herself in her wheel chair in the hall. She was observed to have numerous chin hairs approximately 3/8 inch long. On 02/15/12 at 10:10 AM Resident #94 was observed in the hall in her wheelchair and observed to have numerous chin hairs as described above. On 02/15/12 at 2:00 PM an interview was conducted with Resident #94. She reported staff shaved her facial hair during showers. She went on to say she knows she needs to have her facial hair shaved and she would ask staff to shave it on her next shower day. An interview was conducted on 02/15/12 at 1:50 PM with Nursing Assistant (NA) #3. She reported residents facial hair was removed twice per week during showers, but also checked by NAs as part of daily care. NA #3 stated she trimmed or plucked long facial hairs on female residents whenever she saw them. On 02/15/12 at 2:23 PM an interview was conducted with the Director of Nursing. She reported it was her expectation for NAs to check female residents facial hair on a daily basis and trim or pluck as needed.	F 312		03/15/12
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services	F 322		

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F 322	Continued From page 7 to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and staff interviews the facility staff failed to keep a resident elevated in bed at thirty (30) to forty-five (45) degrees for at least thirty (30) minutes after receiving enteral feeding for one (1) of three (3) residents observed with feeding tubes. (Resident #3) The findings are: Resident #3 was admitted to the facility with the diagnoses of seizure disorder and anemia. Review of Resident #3's annual Minimum Data Set (MDS) dated 09/27/11 revealed she was severely impaired for daily decision making. Further review of the MDS revealed Resident #3 needed extensive assistance for all activities of daily living. The MDS revealed she received nutrition through a gastric tube. Review of Resident #3's care plan dated 10/13/11 revealed she had the potential for aspiration, was to receive nothing by mouth and was fed by a gastric tube. The care plan goals included the resident would maintain a patent airway and would digest gastric feeding without aspiration for ninety days. An intervention for this plan of care was to keep the resident in an upright position of thirty (30) to forty (40) degrees and maintain this	F 322	The resident found to have been affected by the deficient practice has been assessed with no negative outcome noted. A wedge will be placed under this resident's (and all tube fed resident's) mattress to keep head of bed at 30 degrees regardless if the head of the bed is put in the lowest position. The wedge is easily removable by staff for CPR if the need arises. No other resident's have been found to have been affected by this deficient practice. All staff have been in-serviced to the importance of keeping head of bed at 30 to 45 degrees at least 30 minutes after receiving enteral feeding, medication administration, and flushes. Staff in-serviced that wedge cushion is placed under mattress of all tube fed resident's to keep head of bed at 30 degrees regardless if head of bed is put in the lowest position and how to remove wedge for CPR if the need arises. Staff in-serviced to immediately report any issues of not being able to perform ADL's at 30 degrees to the charge nurse so they can make a decision as to how to complete the ADL's. Check wedge placement Q shift will be placed on the MAR of all tube fed resident's so that the charge nurse is checking to make sure wedge is in place. Quality Assurance Nurse will audit CNA incontinence care on tube fed resident's 1x week for 3 months, then monthly thereafter if compliance is accomplished. The Director of Nursing or RN Supervisor will be notified if concerns are noted and staff will be educated if problems have been identified.	

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F 322	Continued From page 8 position for thirty (30) to forty-five (45) minutes after feeding, medication administration, and flushes. Review of the monthly physician orders revealed Resident #3 received enteral feeding via a gastric tube at 60 milliliters per hour from 4:00 PM to 8:00 AM. An observation was made on 02/16/12 at 9:45 AM of Resident #3 lying in her bed with the head of the bed elevated at approximately forty-five (45) degrees. The feeding pump was connected to the resident's gastric tube and infusing the enteral feeding at a rate of sixty (60) milliliters per hour. An observation was made on 02/16/12 at approximately 9:48 AM of Nursing Assistant (NA) #2 entering Resident #3's room carrying linen and Licensed Nurse (LN) exiting Resident #3's room. An observation was made on 02/16/12 at 9:50 AM of Nursing Assistants (NA) #1 and #2 providing care for Resident #3. The feeding pump had been disconnected from the resident's gastric tube. The feeding pump was on hold and the hold alarm began sounding while NA staff were providing care. The head of the bed had been lowered to approximately one inch above absolutely flat. The bed remained in this position for approximately fifteen minutes while NA #1 and #2 performed a bed bath as well as incontinence care for Resident #3. While NAs were providing care LN #1 came into the room and turned off the feeding pump at that time she made no comment to staff regarding the position of Resident #3's bed.	F 322		

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F 322	Continued From page 9 On 02/16/12 at 11:33 AM an interview was conducted with NA #1. She reported that if Resident #3 had not been so soiled they would not have had to lay her flat to clean her. She reported the head of the bed is usually elevated for Resident #3. She further reported the resident should have the head of the bed raised for thirty (30) minutes after tube feeding. An interview was conducted on 02/16/12 at 11:37 AM with NA #2. She reported that Resident #3's head was to be elevated at forty-five (45) degrees but she laid her down to change her. She further reported she did not know when the feeding had been stopped. An interview was conducted on 02/16/12 at 11:45 AM with Licensed Nurse #1. She reported she was late in turning off Resident #3 's feeding. She reported Resident #3's head should be elevated at thirty (30) to forty-five (45) degrees at all times. She further stated staff should not lay her down after feeding. An interview was conducted on 02/16/12 at 12:25 PM with the Director of Nursing (DON). She reported that right after tube feeding there is a high risk of aspiration when laying a resident flat. She reported that if the NAs were unable to clean the resident without reclining her she would expect them to get the nurse to come to the room to problem solve and figure out how to clean the resident.	F 322		03/15/12