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	03/06/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on record review, observation, and staff interviews, the facility failed to develop an accurate baseline care plan for a resident (Resident #303) when the care plan did not include the indwelling catheter that was present on admission for Resident #303. This deficient practice occurred for 1 of 2 residents reviewed for baseline care plans. Findings included: Resident #303 was admitted to the facility on [DATE]. An admission nursing assessment dated [DATE] completed by Nurse #1 documented under the section genitourinary, a catheter was used. The admission Minimum Data Set assessment had not been completed yet. A baseline care plan dated 2/28/25 was not marked for an indwelling catheter. An observation was conducted on 3/3/25 at 11:20 AM of Resident #303 in her room in bed with an indwelling catheter draining to a bedside drainage bag. An order dated 3/4/25 read, [indwelling] urinary catheter 14 french with 10 milliliter (ml) balloon. An interview was conducted on 3/6/25 at 10:07 AM with Nurse #1. She recalled completing Resident #303's admission on 2/28/25 and that Resident #303 had an indwelling catheter on admission. Nurse #1 stated she should have put the indwelling catheter for Resident #303 on the baseline care plan but had missed it. An interview was conducted with the Minimum Data Set (MDS) Nurse on 3/6/25 at 9:57 AM. She explained baseline care plans were completed by the admitting nurse. The MDS Nurse stated an indwelling catheter should be included in the baseline care plan. She stated she did not typically review the baseline care plans. The MDS nurse was not sure what the process was for reviewing the baseline line care plan for completion and accuracy and deferred to the Director of Nursing (DON). (continued on next page)

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

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	345447	A. Building B. Wing	03/06/2025

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing on 3/6/25 at 11:27 AM. She explained the baseline care plan was done by the admitting nurse on admission. She stated the indwelling catheter for Resident #303 should have been on the care plan but it was missed. The DON said after the baseline care plan was completed by the admitting nurse, the care plan went to medical records and was scanned into the resident's electronic medical record. The DON reported she did not review baseline care plans. The DON said there was not a current process for reviewing baseline care plans for completion and accuracy. An interview was conducted with the Administrator on 3/6/25 at 4:55 PM. The Administrator stated the baseline care plan should have included Resident #303's indwelling catheter and that it had been missed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on record review and staff interviews, the facility failed to develop an accurate comprehensive care plan for a resident (Resident #10) when the care plan did not include a plan of care for pain. This deficient practice occurred for 1 of 1 resident reviewed for pain. Findings included: Resident #10 was admitted to the facility on [DATE] with the following diagnoses: unspecified fracture of shaft of left femur, unspecified fracture of upper end of left humerus. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 was cognitively intact. The MDS documented that she had moderate pain, at a frequency of almost constantly, and she received as needed (PRN) pain medication. The MDS further documented that she received an opioid medication. The Care Area Assessment 2/11/25 revealed Resident #10 had triggered for pain and indicated she should be care planned for pain. A physician order dated 2/13/25 read, oxycodone (pain medication) 5 milligrams (mg) oral tablet, give 2.5 mg by mouth every eight hours as needed for pain. Resident #10's care plans last reviewed on 3/3/25 did not include a care area for pain. An interview was conducted with the Minimum Data Set (MDS) nurse on 3/6/25 at 9:57 AM. The MDS nurse said Resident #10's care plan should have included pain. She explained Resident #10 had triggered for pain on the Care Area Assessment when she had completed her admission MDS. The MDS nurse further explained she had started a care plan for pain for Resident #10 but had never clicked the finish button. The MDS nurse said it was an oversight, and it had been missed. An interview was conducted with the Director of Nursing on 3/6/25 at 11:27 AM. She said Resident #10's care plan should have included pain and that it had been missed by the MDS nurse. An interview was conducted with the Administrator on 3/6/25 at 4:55 PM. The Administrator stated Resident #10 should have been care planned for pain and it had just been missed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on record review, observations, and staff and Wound Care Nurse Practitioner (NP) interviews, the facility failed to assess for and identify a pressure ulcer on the buttock before it was assessed as a stage III (full-thickness loss of skin) for 1 of 2 residents (Resident #10) reviewed for pressure ulcers. Findings included: The hospital discharge summary dated 2/7/25 indicated Resident #10 was admitted to the hospital with a left femur fracture and had a surgical procedure to repair her left femur fracture on 2/4/25. The discharge summary reported an x-ray was completed on 2/4/25 that showed a humerus fracture. The discharge summary indicated she had surgical incisions to her left lower extremity. The discharge summary did not mention any other wounds or skin abnormalities. Resident #10 was admitted to the facility on [DATE] with the following diagnoses: unspecified fracture of shaft of left femur, unspecified fracture of upper end of left humerus, and impaired mobility. The admission nursing assessment dated [DATE] documented a stage I pressure area to the coccyx and bruising to her left upper/ lower extremities. The treatment administration record (TAR) for February 2025 and revealed there were no treatment orders for a stage I pressure ulcer to the coccyx. A Braden scale assessment (assessment for predicting pressure ulcer risk) dated 2/9/25 indicated Resident #10 was low risk for developing pressure ulcers. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 was cognitively intact. The MDS documented she was at risk of developing a pressure ulcer. The MDS documented that she had a surgical wound but that she did not have a pressure ulcer. The MDS further documented that she was not receiving any skin or ulcer treatments. An order entered by Unit Manager (UM) #1 was dated 2/11/25 and read: weekly skin integrity review every evening shift every Tuesday, Friday for monitoring skin. A review of Resident #10's electronic medical record revealed weekly skin assessments had not been completed since her admission. There were no skin assessments documented for the weeks of 2/11/25, 2/18/25, or 2/25/25. (continued on next page)

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	345447	A. Building B. Wing	03/06/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with UM #1 on 3/4/25 at 1:57 PM. UM#1 recalled she entered the order for Resident #10's weekly skin assessments. UM #1 reviewed the order and reported the order had been put in wrong. UM #1 explained because the order was put in wrong it would not pull to the medication administration record (MAR) for the nurses to see and the nurses would not know they needed do the skin assessment. UM #1 said weekly skin assessments were supposed to be completed weekly not twice weekly. She said Resident #10 had changed rooms and when she moved rooms the skin assessment day for the new room was added to the order, but the prior rooms skin assessment day was not removed from the order. A telephone interview was conducted with NA #3 on 3/5/25 at 3:37 PM. She recalled being assigned to care for Resident #10. She reported she remembered seeing a wound to Resident #10's buttocks. She said it was one of the days when she had been assigned to work on E hall, where Resident #10 resided on 2/20/25 or 2/21/25. NA #3 remembered Resident #10 had a skin tear she thought it was on her right buttock cheek but said it could have been on the left side. She stated she had talked to the Wound Care Nurse about it. NA #3 explained the Wound Care Nurse had told her she already knew about the area and told her to put zinc on it. NA #3 said she had gone into Resident #10's room with the Wound Care Nurse to roll Resident #10 so the Wound Care Nurse could look at the wound. NA #3 recalled she had also been working on 2/25/25 and had helped on E hall that day, but said it was before that day when she had reported the area to Resident #10's buttocks and had gone into Resident #10's room with the Wound Care Nurse to look at the wound with her. A telephone interview was conducted with NA #2 on 3/5/25 at 3:44 PM. She recalled being assigned to care to Resident #10 on 2/16/25, 2/18/25 and 2/24/25 day shift (7a-3pm). She reported she did not remember seeing any wounds to her buttocks when she assisted her with incontinent care. She reported Resident #10 sometimes did not want to do things like get out of bed or turn/ reposition. An interview was conducted with the Wound Care Nurse on 3/6/25 at 10:30 AM. The Wound Care Nurse reported a wound to Resident #10's buttocks was not reported to her by NA #3 on 2/20/25 or 2/21/25. She did not recall telling NA #3 to put zinc on a wound to Resident #10's buttocks. She said the wound to Resident #10's buttocks had been reported to her on 2/25/25 by the Physical Therapist. The Physical Therapist was unavailable to be interviewed. A change of condition situation background assessment and recommendations (SBAR) note completed by the Wound Care Nurse was dated 2/25/25. The note indicated Resident #10 had an open area to her buttocks. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Wound Care Nurse on 3/4/25 at 1:54 PM. The Wound Care Nurse explained Resident #10's pressure ulcer was found last week on 2/25/25 and was a stage 3 pressure ulcer when it had been found. The Wound Care Nurse explained she thought skin assessments were supposed to be completed twice a week for residents. The Wound Care Nurse further explained there was an order entered into the electronic computer system for the resident's skin assessment so it would populate and pull to the MAR for the nurses to see. She stated the order was the trigger for nurses to know they needed to go and do the skin assessment. The Wound Care Nurse reviewed the order for Resident #10's skin assessment and said the order had been entered incorrectly. She said the order was not put in to pull to the MAR and because the order did not show up on the MAR the nurses would not have known they needed to do the skin assessment for Resident #10. The Wound Care Nurse reported the skin assessment was separate from the daily skilled nursing note and was not included in the daily skilled nursing note. The Wound Care Nurse verbalized the non-pressure ulcer skin condition assessment was a monitoring tool used to monitor wounds such as surgical wounds. The Wound Care Nurse reported Resident #10 was already being followed by the Wound Care NP for her surgical wound and that when the stage 3 pressure ulcer had been found Resident #10 was seen by the Wound Care NP for evaluation of her pressure ulcer. The Wound Care Nurse recalled Resident #10 had a stage 1 pressure ulcer documented to her coccyx on the admission assessment but reported she had looked at Resident #10's skin to her buttocks a couple of days after her admission and had not seen a wound to her buttocks. She said, even if Resident #10 had a stage 1 pressure ulcer to her coccyx on admission that it would be different because her stage 3 pressure ulcer was to her left buttocks not her coccyx. The Wound Care Nurse stated she thought the pressure ulcer to Resident #10's buttocks would have probably been identified and found before it was a stage 3 pressure ulcer if weekly skin assessments had been completed. A review of Resident #10's electronic medical record revealed she had an order dated 2/27/25 for an air mattress to promote offloading. A care plan with an initiation date of 2/28/25 and last revised on 3/3/25 was present for potential for impairment to skin integrity related to incontinence, impaired bed mobility, and risk for skin breakdown. The care plan included Resident #10 had a stage 3 pressure wound to her left buttocks. The care plan interventions included: air mattress as ordered, assist to turn/ reposition in bed frequently, avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, encourage good nutrition and hydration, incontinence care as ordered, monitor/ document location, size and treatment of skin injury. An interview and observation was completed of Resident #10 on 3/3/25 at 2:17 PM. Resident #10 was observed sitting up in her wheelchair. A pressure reduction cushion was observed in the seat of her wheelchair and an air mattress was in place to her bed. Resident #10 said she had a wound to her buttocks that had developed after admission, she did not recall exactly when the wound had developed. She stated the facility was treating the wound to her buttocks and it was getting better. She reported that staff assisted her with turning/ repositioning frequently and assisted her with incontinent care when needed. A progress note dated 3/4/25 by the by the Register Dietician (RD) indicated Resident #10 was seen on 3/4/25 and Prostat (protein supplement) 30 milliliters daily was added to aid wound healing. The RD note indicated her weights were being monitored and the RD would continue to follow her due to her wound. (continued on next page)

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	345447	A. Building B. Wing	03/06/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Nurse #2 on 3/4/25 at 1:30 PM. Nurse #2 explained skin assessments for residents were supposed to be completed weekly. She further explained that the weekly skin assessment was separate and different than daily skill nursing notes and that a skin assessment was not part of the daily skilled nursing note. Nurse #2 reported she knew when she needed to complete a weekly skin assessment because it would pop up on the MAR to indicate the assessment needed to be completed. Nurse #1 said she only did assessments if the assessment was on the MAR to complete it. She explained if a weekly skin assessment did not show up on the MAR then she would not know it needed to be completed. An observation of Resident #10's wound was conducted on 3/5/25 at 9:30 AM with the Wound Care NP. The Stage III pressure ulcer to Resident #10's left buttocks was assessed and measured by the Wound Care NP. The wound measured 1.1 x 1.3 x 0.2 centimeters (cm), the wound bed was red/ pink in color with 60 % granulation (new tissue growth) and 40 % intact tissue, there was no odor, no slough (material that overlays the wound bed and can hinder healing), no drainage, and no signs/ symptoms of infection. An interview was conducted with the Wound Care NP on 3/5/25 at 9:33 AM. The Wound Care NP explained Resident #10's wound had improved and was healing. She said Resident #10's pressure ulcer had been full thickness when she originally saw it. The Wound Care NP reported Resident #10 had areas of hyperpigmentation (discoloration) to her buttocks that was evidence she had prior wounds to other areas of her buttocks in the past and that there could have possibly been a prior wound to the area where the stage III pressure ulcer was located. The Wound Care NP explained she had no indication for sure that there was a prior wound to the area or what the wound was if there had been one there and so she had classified Resident #10's wound as a stage III pressure ulcer. She explained the wound to resident #10's left buttocks could not be the stage I area to the coccyx identified on the admission assessment, she said that it was a different location. The Wound Care NP said skin assessments were important to identify new skin impairments. She stated she could not say if Resident #10's pressure ulcer could have been identified earlier before it was a stage III because of evidence there may have been a wound prior to that area. The Wound Care NP verbalized she could not say how fast a stage III pressure ulcer wound could develop. She explained how fast a wound developed was individualized and based on risk factors such as age, debility, mobility, nutrition. She reported the Braden scale assessment was one of the most common standardized tools used to identify the risk of pressure ulcer development and that there was a correlation with individuals who developed pressure ulcers and the Braden score. An interview was conducted with the Director of Nursing on 3/6/25 at 11:27 AM. The DON said she was aware of Resident #10's left buttocks stage III pressure ulcer. The DON stated she was not aware Resident #10 had not had skin assessments completed since her admission. The DON reported skin assessments were supposed to be completed weekly. She explained the nurses would not have known to do the skin assessments for Resident #10 because the order had been put in wrong and did not pull to the MAR for them to see. The DON explained skin assessments were important to identify new skin issues. An interview was conducted with the Administrator on 3/6/25 at 4:55 PM. The Administrator reported the purpose of skin assessments was to determine skin integrity. The Administrator stated Resident #10's skin assessments were probably missed because it did not show up on the MAR to trigger the nurses to do the assessment. .

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	345447	A. Building B. Wing	03/06/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on observations, record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to ensure the resident had medical diagnoses to support an indwelling urinary catheter and to keep a urinary catheter bag and its tubing from touching the floor to reduce the risk of infection for 1 of 1 resident reviewed with a urinary catheter (Resident #303). Findings included: Resident #303 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation and chronic obstructive pulmonary disease (COPD). A discharge summary dated 2/28/25 did not include information or an indication for Resident #303's indwelling catheter. An admission nursing assessment dated [DATE] completed by Nurse #1 documented under the section genitourinary, a (urinary) catheter was used. The admission Minimum Data Set assessment had not been completed yet. A baseline care plan dated 2/28/25 was not marked for an indwelling catheter. An order dated 3/4/25 read, [indwelling] urinary catheter The order did not include a diagnosis or indication of use for the catheter. a. An interview was conducted on 3/3/20 at 11:20 AM with Resident #303. She stated she did not have an indwelling urinary catheter before she went to the hospital. She did not know why she had the indwelling urinary catheter. Further review of Resident #303's medical record revealed there was no indication or diagnosis for her indwelling urinary catheter. An interview was conducted with the Nurse Practitioner (NP) on 3/6/25 at 10:50 AM. The NP reviewed Resident #303's electronic medical record and reported she did not see an indication for her indwelling urinary catheter. She stated there should be a diagnosis for an indwelling catheter to specify why it was needed. The NP explained indwelling catheters should be removed as soon as possible when there was not a clear indication for use. She further explained, an indwelling catheter was an indwelling device and increased the risk of developing an infection. An interview was conducted with the DON on 3/6/25 at 11:27 AM. The DON stated Resident #303 should have a diagnosis that supported why she needed an indwelling catheter. The DON explained Resident #303's catheter being reviewed to ensure there was a diagnosis, had been missed. The DON said an indwelling catheter being left in place increased the risk of infection. (continued on next page)

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	345447	A. Building B. Wing	03/06/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Administrator on 3/6/25 at 4:55 PM. The Administrator said there should be an indication for an indwelling catheter, and catheters should be removed if there was not one. She said an indwelling catheter was an indwelling device and increased an individual's risk of developing an urinary tract infection b. An observation was conducted on 3/3/25 at 11:20 AM of Resident #303 in her room in bed. She was observed to have an indwelling urinary catheter draining to a bedside drainage bag. The bedside drainage bag and tubing was observed on the floor under the bed. A follow up observation was conducted on 3/3/25 at 3:03 PM of Resident #303's indwelling urinary catheter drainage system. The bedside drainage bag was observed positioned below bladder level and hanging on the bottom rail of the bed frame. An additional observation was conducted on 3/6/25 at 9:14 AM of Resident #303 in her room resting in bed. Her indwelling urinary catheter was observed draining to a bedside drainage bag. The urinary catheter drainage bag and tubing was resting on the floor under the bed. An interview was conducted with Nurse #1 on 3/6/25 at 10:07 AM. She was not aware Resident #303's catheter drainage bag and tubing was on the floor. Nurse #1 said catheter bags and tubing should not be on the floor because of contamination and infection risk. An interview was conducted with Nurse Aide (NA) #1 at 10:27 AM. NA #1 stated she had gone into Resident #303's room this morning to deliver her breakfast tray. She explained she had not seen the urinary catheter drainage bag or tubing on the floor. NA #1 reported catheter bags and tubing should not be on the floor because it was unsanitary and increased the risk of infection. NA #1 said catheter bags were supposed to be positioned below the level of the bladder and hung on the bed frame rail. An interview was conducted with the Director of Nursing on 3/6/25 at 11:27 AM. The DON stated urinary catheter bags and tubing should be kept off the floor to prevent infection. The DON explained the urinary catheter bag should be hung on the side of the bed below the level of the bladder when a resident was in bed. An interview was conducted with the Administrator on 3/6/25 at 4:55 AM. The Administrator reported urinary catheter drainage bags and tubing should not be on the floor for infection control reasons, it could leak, or someone could step on it.

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	345447	A. Building B. Wing	03/06/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51140 Based on observations, record review, and resident, and staff interviews, the facility failed to ensure that oxygen air filters were present, clean, and without dust for 2 of 3 residents reviewed for respiratory care (Resident #25 and Resident #78). The findings included: 1. Resident #25 was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure. Review of a significant change Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #25's cognition was moderately impaired. A review of physician orders dated 03/03/2025 at 7:00 AM revealed an order for continuous oxygen at 2 liters per minute via nasal cannula every shift. An observation conducted on 03/03/2025 at 1:08 PM, Resident #25 was observed lying in bed with his head of bed elevated. His oxygen cannula was in place to both nostrils with an oxygen setting of 2 liters per minute. The oxygen concentrator had a place for an oxygen air filter, and it was noted that the filter was missing as was the filter cover. An observation conducted on 03/04/2025 at 10:10 AM, Resident #25 was lying in bed with his head of bed elevated. A nasal cannula was attached to an oxygen concentrator that did not have an oxygen air filter or filter cover, and the oxygen was set to deliver 2 liters per minute. An observation was conducted on 03/05/25 at 8:33 AM, Resident #25 was observed lying in bed with oxygen in use at 2 liters per minute. There was no oxygen air filter or filter cover observed on the resident's oxygen concentrator. An observation was conducted on 03/06/25 at 8:00 AM, Resident #25's was resting in bed with oxygen in use at 2 liters per minute. The oxygen concentrator was noted to have no oxygen air filter or filter cover. An observation on 03/06/2025 at 2:20 PM, Resident #25 was observed with oxygen at 2 liters per minute via nasal cannula while lying in bed. The oxygen concentrator did not have an oxygen air filter or filter cover. An observation was conducted on 03/06/25 at 2:29 PM with Unit Manager #2 of Resident #25's oxygen concentrator. Unit Manager #2 acknowledged that the oxygen concentrator was missing the oxygen air filter and cover but did not comment on the issue. The Director of Nursing (DON) was notified on 03/06/25 at 3:15 PM of Resident #25's missing oxygen air filter and cover and did not comment on the issue. (continued on next page)

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	345447	A. Building B. Wing	03/06/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed at 4:52 PM on 03/06/2025 and stated that Resident #25's oxygen concentrator should have the required oxygen air filter with cover. 2. Resident #78 was admitted on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #78's cognition was intact and received oxygen therapy. A review of the physician orders revealed that continuous oxygen was order at 2 liters per minute via nasal cannula on 12/17/2024. Upon observation at 11:02 AM on 03/03/2025, Resident #78 was sitting in her wheelchair at bedside with a nasal cannula attached to an oxygen concentrator set to deliver 2 liters per minute. The filter on the oxygen concentrator had a grayish/white material covering the filter. Unit Manager #2 entered Resident #78's room at 2:27 PM on 03/03/2025 and when interviewed stated that she noted the dirty air filter on the concentrator. At 9:52 AM on 03/04/2025 Resident #78 was sitting in a wheelchair wearing a nasal cannula and receiving Oxygen at 2 liters per minute via oxygen concentrator with a filter that had gray matter covering it. On 03/05/2025 at 9:20 AM while sitting in her wheelchair, Resident #78 was receiving oxygen at 2 liters per minute via nasal cannula attached to an oxygen concentrator with a filter that had a large amount of gray substance on it. An observation at 03/06/2025 at 7:59 AM revealed that Resident #78 was sitting on her bedside receiving oxygen at 2 liter per minute via nasal cannula by oxygen concentrator. There was caked dust on the outside of the filter on the concentrator. Upon interview at 7:59 AM on 03/06/2025, Resident #78 stated that she didn't know when the filter had been changed or cleaned and didn't realize the machine had one. An interview was conducted with both Unit Manager #1 and Unit Manager #2 at 3:05 PM on 03/06/2025, the findings at 2:27 PM of Resident #78's dirty air filter on the concentrator were revealed, neither manager made a comment. An observation and interview were conducted with the Director of Nursing (DON) on 03/06/25 at 3:15 PM. The DON was informed that Resident #78's oxygen filter was covered with grey/white dust, and she stated some oxygen concentrators had internal filters but did not comment on the gray/white dust on the filter. The Administrator was interviewed at 4:52 PM on 03/06/2025 and stated that the air filters on oxygen concentrators such as Resident #78's should be cleaned and that it was not appropriate to be dirty with dust. She revealed that an air filter should be used with an oxygen concentrator such as with Resident #78.

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	03/06/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272 Based on record review, and staff, Nurse Practitioner (NP), and Consultant Pharmacist interviews, the facility failed to act on a pharmacy recommendation to add a stop date for a PRN antipsychotic medication (Resident #17). This deficient practice occurred for 1 of 5 residents reviewed for pharmacy recommendations. Findings included: Resident #17 was admitted on [DATE] was diagnosis that included post-traumatic stress disorder (PTSD), schizophrenia and bipolar disorder. A review of Resident #17's physicians orders found an active order dated 12/1/24 for Haloperidol injection solution inject 5 milligrams (MG) intramuscularly every 4 hours as needed (PRN) for agitation. A December pharmacy recommendation dated 12/2/24 read in part Resident #17 had an order for Haloperidol without a stop date. The review wrote PRN antipsychotic orders were only good for a maximum of 14 days. The recommendation was signed by the NP on 3/5/25 and agreed to stop the PRN medication. A review of Resident #17's quarterly minimum data set (MDS) dated [DATE] had her coded for severe cognitive impairment. She was coded yes for taking an anti-psychotic medication. The Director of Nursing (DON) was interviewed on 3/06/25 at 1:11 PM. The DON stated the PRN antipsychotic medications needed a 14-day stop date. The DON said after 14 days, the medication needed to have a new order from the physician. Resident #17 was ordered the antipsychotic medication by an on-call provider for agitation and a 14 day stop date was not placed on the order. The DON stated Resident #17's December 2024 pharmacy recommendation was not signed off by the new psychiatry provider. The new psychiatry provider had not added Resident #17 as a patient at that time and didn't sign the recommendation. The DON stated the Pharmacy recommendation was misplaced and was signed on 3/5/25 by the psychiatry provider and the PRN medication was stopped. The Consultant Pharmacist was interviewed via phone on 3/06/25 at 4:22 PM. He said he completed pharmacy reviews each month. He stated he did not indicate any pharmacy recommendations for Resident #17 after the initial recommendation, but he did speak with the DON when he completed monthly reviews and told her about the needed 14-day PRN stop date. The Nurse Practitioner (NP) was interviewed on 3/6/25 at 1:41 PM. The NP stated she was not aware PRN antipsychotic medications required a 14 day stop date. The NP said she reviewed resident medications and if they had an antipsychotic medication, she reviewed the history but did not usually stop the medication because that was not her specialty. The NP stated she referred to psychiatry to evaluate antipsychotic medications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272 Based on record review, and staff, Pharmacy Representative, and Nurse Practitioner (NP) interviews, the facility the facility failed to include a 14- day stop date with an order for a PRN antipsychotic medication (Resident #17). This deficient practice occurred for 1 of 5 residents reviewed for pharmacy recommendations. Findings included: Resident #17 was admitted on [DATE] was diagnosis that included post-traumatic stress disorder (PTSD) and schizophrenia bipolar disorder. A review of Resident #17's physicians orders found an active order dated 12/1/24 for injection solution, inject 5 milligrams (MG) intramuscularly every 4 hours as needed (PRN) for agitation. A review of Resident #17's quarterly minimum data set (MDS) dated [DATE] had coded her as severely cognitive impaired. She was coded yes for taking an anti-psychotic medication. The Director of Nursing (DON) was interviewed on 3/06/25 at 1:11 PM. The DON stated the PRN antipsychotic medications needed a 14-day stop date. The DON said after 14 days, the medication needed to have a new order from the Physician. Resident #17 was ordered the antipsychotic medication by an on-call provider for agitation and a 14 day stop date was not placed on the order. The DON stated the PRN medication was stopped. The Nurse Practitioner (NP) was interviewed on 3/6/25 at 1:41 PM. The NP stated she was not aware PRN antipsychotic medications required a 14 day stop date. The NP said she reviewed resident medications and if they had an antipsychotic medication, she reviewed the history but did not usually stop the medication because that was not her specialty. The NP stated she referred to psychiatry to evaluate antipsychotic medications. A Pharmacy Representative was interviewed on 3/6/25 at 2:44 PM. The representative stated PRN antipsychotic medications require a 14-day stop date when ordered by a provider. The Administrator stated on 3/6/25 at 4:48 PM PRN antipsychotic medications needed to have a stop date of 14 days when ordered.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272 Based on observation, record review, and staff interviews, the facility failed to provide drinks consistent with the resident's thickened liquid needs for 1 of 1 sampled resident (Resident #73) reviewed for drinks available to meet resident needs. Findings included: Resident #73 was admitted on [DATE] with diagnoses that included dementia and dysphagia. Resident #73's quarterly Minimum Data Set (MDS) dated [DATE] was reviewed. Resident #73 was coded for severe cognitive impairment. Resident #73 was also coded for receiving a mechanically altered diet. Resident #73 had a physician's order dated 12/4/24 for regular diet, dysphagia puree texture with honey thickened fluids. On 3/6/25 at 12:25 PM in the locked unit dining room, the Speech Therapist notified the surveyor Resident #73 received thin liquids on his meal tray. The Speech Therapist said Resident #73 needed honey thickened liquids for safe swallowing, and it was written on the meal ticket. Resident #73 was observed sitting at a table with a family member who was assisting the resident with the meal. Resident #73 had not drunk any of the thin liquid. The thin liquid beverage was removed from the tray and replaced with a honey thickened beverage by the Speech Therapist. Resident #73's meal ticket read, regular, dysphagia puree, honey thick liquids. During the observation, the Regional Dietary Consultant stated the honey thick liquid was overlooked on the tray line. The Administrator stated on 3/6/25 at 4:48 PM the meal trays needed to be double checked on the tray line to ensure the residents received the correct liquid consistency.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272 Based on observations and staff interviews, the facility failed to date opened containers of thickened liquids and clean 1 of 1 reach-in refrigerators. The facility also failed to remove expired chocolate milk from a nourishment room (the Secured Unit nourishment room). These practices had the potential to affect food served to the residents. Findings included: a. On [DATE] at 9:51 AM an observation of the reach-in refrigerator in the kitchen found 3 containers of thickened liquid that were opened and did not contain an open date. The Dietary Manager (DM) stated during the observation he thought the thickened liquids were used for breakfast, but should have been dated before storing in the refrigerator. On [DATE] at 9:54 AM the bottom of the reach-in refrigerator was observed with a sticky to touch residue. The bottom of the refrigerator also contained food debris spread around the bottom of the refrigerator. The DM stated during the observation that he was unsure when the refrigerator was last cleaned. The DM stated he started working as the facility's DM the previous week and was still learning the kitchen cleaning schedules. b. On [DATE] at 2:49 PM an observation of the locked resident unit's refrigerator found 4 cartons of unopened chocolate milk with an expiration date of [DATE]. The DM stated during the observation that the expired milk was not in the refrigerator when he checked it earlier in the day and was unsure who had placed the milk in the refrigerator. The Administrator stated on [DATE] at 4:48 PM the kitchen and all food storage areas should be cleaned and maintained. The Administrator said expired food items should be removed and disposed of and the opened thickened liquids should have been dated when opened.