STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Ridge Health and Rehabilitation	25 Reynolds Mountain Boulevard Asheville, NC 28804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, power of attorney (POA), Nurse Practitioners, Psychiatrist and Medical Director, the facility failed to ensure Resident #101, who was admitted on [DATE] following a stay at an inpatient psychiatric facility beginning on 1/9/26 for a severe episode of recurrent major depressive disorder with suicidal behavior with attempted self-injury, received the necessary treatment that was person-centered and individualized to meet her needs. The resident's psychiatric diagnoses included major depressive disorder, post-traumatic stress disorder (PTSD), bipolar disorder, and delusional disorders. The inpatient psychiatric facility's discharge summary included an order for antipsychotic medication (olanzapine) every night at bedtime. This order was inaccurately transcribed as a PRN (as needed) order and was administered once during the resident's stay at the facility. The Psychiatrist from the inpatient psychiatric facility indicated that olanzapine did not work as a PRN medication when utilized for depression or psychosis and if it was stopped on a person with bipolar disorder, their psychotic and mood symptoms would eventually come back. A care plan with individualized approaches that addressed the resident's prior suicide attempts and suicidal ideation was not developed in order to protect the resident from further suicidal behaviors. Multiple staff who worked with the resident were not aware of her history of suicide attempts, and a statement made by the resident that she would be better off dead than staying at the facility were not communicated to all staff or documented. On 2/6/26, Resident #101 was found by staff lying in bed with a safety razor in hand and blood on hands, wrists and abdomen with multiple shallow lacerations to bilateral wrists, bilateral antecubital (inner crook of the elbow) areas and right neck. Resident #101's eyes were half open and half closed and she was unresponsive to staff except for painful stimuli. She had labored breathing and bounding pulse. Resident #101 was transferred to the emergency department for evaluation. No lacerations required closure. Resident #101 was treated for urinary tract infection and was psychiatrically cleared and ready for placement in a non-psychiatric facility on 2/10/26. This deficient practice was for 1 of 1 resident reviewed for behavioral health services. Immediate jeopardy began on 2/6/26 when Resident #101, who had been admitted to the facility following a stay at an inpatient psychiatric unit precipitated by the self-harming behavior of superficial lacerations to her wrists, was not provided with the necessary behavioral health care to prevent the resident from obtaining a safety razor and making shallow lacerations to her bilateral wrists, bilateral antecubital areas, and right neck. The immediate jeopardy was removed on 4/6/26 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity (D - no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education was in place and monitoring systems that were put into place were effective.The findings included:A review of the History & Physical for Resident #101 dated 1/9/26 which was in Resident #101's medical record indicated the resident was a [AGE] year old female who was admitted to the inpatient psychiatric facility on 1/9/26 for inpatient psychiatric care. She initially presented to the Emergency Department (ED) from (continued on next page)

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.

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

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	initiated on 1/28/26 indicated Resident #101 used antidepressant medication related to depression (history of suicidal ideation). The goal read: the resident will show decreased episodes of signs/symptoms of depression (suicidal ideation) through the review date. The interventions included: 15-minute checks times (x) 72 hours as needed, administer antidepressant medications as ordered by physician, monitor/document side effects and effectiveness every shift, educate the resident/resident representative about risks, benefits and the side effects and/or toxic symptoms, monitor/document/report as needed adverse reactions to antidepressant therapy and psychiatric consult as needed. There were no specific interventions related to suicide precautions.A review of an Initial History and Physical dated 1/28/26 by the Medical Director indicated Resident #101 had been initiated in physical therapy and occupational therapy. She reported that she was anxious to do all the therapy and wanted to improve her functional independence. She slept well overnight, denied any increased mood symptoms or suicidal ideation, and her appetite was stable. Resident #101 refused the PHQ-9 stating, I don't want to answer those questions. Her psychiatric diagnoses included mood disorder with anxiety. No increased nervousness or depression were noted. She continued on olanzapine and trazodone which were recently initiated in the hospital when she had suicidal ideation. Will have behavioral health services continue to evaluate and treat.A review of a Pharmacy Consultation Report issued on 1/28/26 for Resident #101 indicated Resident #101 was recently admitted to the facility. The medication review process revealed the following discrepancies on the admission orders: hospital discharge summary listed olanzapine as routine but it was PRN x 14 days in the electronic medical record.A review of an Order Summary Report for Resident #101 dated 1/29/26 indicated an order for olanzapine disintegrating oral tablet 5 mg every 24 hours PRN for mood for 14 days. This order was started on 1/26/26 with an end date of 2/9/26. The report was signed by NP #2 on 1/29/26.Further phone interview with NP #2 on 4/2/26 at 3:27 PM revealed she signed off on the order summary report two days after she had already seen Resident #101, and she did not review the medication orders in Resident #101's medical record or check them against the inpatient psychiatric facility's discharge summary medication list. NP #2 stated that the order summary report was just a list of all current orders which she normally signed off on and reviewed after she had already visited the resident.A review of a Psychiatric Periodic Evaluation dated 1/29/26 by the Psychiatric-Mental Health Nurse Practitioner indicated Resident #101 was seen today at the request of staff. She was seen in her bed and had just completed therapy. She appeared to be calm and reported that she was feeling okay. She reported that she had been sleeping okay and her appetite was good. When asked about any suicidal or homicidal ideation, she stated, I have never had that. When asked why she was admitted to an inpatient psychiatric facility, she stated that she was just having a bad day. Discussed having any suicidal or homicidal thoughts currently and Resident #101 stated that she would never want to hurt anybody else. She denied any suicidal ideation. She stated that she felt safe at the facility. Resident #101 voiced several protective factors which she said prevented her from hurting herself. She reported that she was compliant with her medications. There were no acute changes in mood or mentation reported by staff. Resident #101's olanzapine 5 mg daily PRN for mood was to continue for mood lability (rapid, intense, and uncontrollable shifts in mood) or agitation. The Psychiatric-Mental Health Nurse Practitioner indicated she would reevaluate on next visit.A phone interview with the Psychiatric-Mental Health Nurse Practitioner (PMHNP) on 4/2/26 at 10:13 AM revealed she was familiar with Resident #101 and had seen her in September 2025 at a different long term care/nursing facility. The PMHNP stated that she knew Resident #101 had come from a psychiatric hospital after a suicide attempt from the other facility. She stated that she did not review the discharge summary from the psychiatric hospital, and she did not know that the olanzapine was ordered to be given at bedtime routinely. She added that she assumed it had been ordered as PRN from the psychiatric hospital. The PMHNP stated that during her visit on 1/29/26 with Resident #101, the resident had no hallucinations or delusions and had voiced no suicidal ideation. She shared that the psychiatric hospital had discharged Resident #101 because they had deemed her safe to be at (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Nursing (DON) signed the Pharmacy Consultation Report issued on 1/28/26 related to the discrepancy with the olanzapine being listed in the hospital discharge summary as scheduled but being entered as PRN for 14 days in the facility record. There was a handwritten note that read olanzapine changed to PRN by provider.An interview with the DON on 4/3/26 at 11:46 AM revealed she received the pharmacy recommendation on 2/3/26 which was issued to the facility on 1/28/26 about the olanzapine order. She stated she checked in Resident #101's electronic medical record on 2/3/26 and saw that it was ordered as PRN, so she assumed that it had been changed by the Psychiatric NP. The DON stated that she did not clarify with a provider about the olanzapine order. The DON stated that she misunderstood what the pharmacist was asking about in the recommendation. She stated that she thought the pharmacist was clarifying about having a stop date for the PRN olanzapine which was already in the orders for 14 days. The DON stated that her signature on 2/3/26 meant that she had reviewed the pharmacy recommendation and had addressed it on that date. The DON stated that she did not think about clarifying the olanzapine order with a provider, but she should have. She also stated that they were not doing any double checks on orders for new admissions, so they missed the discrepancy between what was ordered in the electronic medical record and the inpatient psychiatric facility's discharge summary order for olanzapine.An interview was conducted with Nurse #4 on 4/2/26 at 9:16 AM. Nurse #4 stated that Resident #101 often came out to the hallway and screamed or yelled for random things. Nurse #4 shared that Resident #101 could not see at all, so she was always yelling, Where are you?Review of the progress notes in Resident #101's medical record indicated daily documentation from 1/27/26 through 2/5/26 of Resident #101's mood being pleasant and no unwanted behaviors were witnessed.A phone interview with Nurse #6 on 3/31/26 at 3:28 PM revealed she took care of Resident #101 on the night shift, and she was always sleeping at night. Nurse #6 stated that on the morning of 2/6/26 around 6:00 AM, Resident #101 kept on going to other residents' rooms. Nurse #6 stated that one of the nurse aides went to get her out of the resident's room. Nurse #6 stated that she was not aware of any past suicide attempts, and she was not told about any suicide precautions for Resident #101.A phone interview with NA #6 on 4/3/26 at 7:21 AM revealed she usually worked with Resident #101 on the night shift. NA #6 stated that on the night of 2/5/26, Resident #101 was agitated, kept on getting out of bed and apologizing, but she did not specify what she was apologizing for. NA #6 stated that this was the only night she saw Resident #101 being agitated like that. Resident #101 normally just stayed in her bed and rang her call light if she needed to use the bathroom. NA #6 further stated that she did not remember Resident #101 yelling or hollering on the morning of 2/6/26. NA #6 stated that she had worked with Resident #101 and she had never made any statements about wanting to die or kill herself. NA #6 further reported that she was not aware of Resident #101's previous history of attempting suicide, and that she was not told about any kind of suicide precautions for Resident #101.Resident #101's MAR from admission on [DATE] through 2/6/26 revealed no monitoring and/or documenting of behaviors. A review of Resident #101's MAR for 1/31/26 through 2/6/26 indicated PRN olanzapine 5 mg was not administered.A review of a Change in Condition form for Resident #101 dated 2/6/26 at 8:47 AM and completed by Nurse #5 indicated the resident was found lying in bed with a safety razor in hand and copious amount of blood on hands, wrists and abdomen. Multiple shallow lacerations noted to bilateral wrists, bilateral antecubital areas and right neck. Resident #101 only responded to painful stimuli. Her respiratory rate was 30 per minute (normal 12 to 20 breaths per minute) and her oxygen saturation (measures the percentage of oxygen-saturated hemoglobin compared to total hemoglobin in the blood indicating how effectively red blood cells deliver oxygen throughout the body) was 88% (normal 95%-100%) on room air. She had labored or rapid breathing and shortness of breath. Resident #101 had altered level of consciousness and was unresponsive. Interventions included to call 911 for emergency medical transport.A phone interview with Nurse Aide (NA) #5 on 3/31/26 at 2:54 PM revealed on 2/6/26 when she was about to bring Resident #101's breakfast tray, she noticed that Resident #101's door was closed. NA #5 stated it was unusual for (continued on next page)

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	345447	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address concerns voiced by residents during Resident Council meetings for 11 of 12 months reviewed (April 2025, May 2025, June 2025, July 2025, August 2025, September 2025, October 2025, November 2025, January 2026, February 2026 and March 2026).The findings included: A review of the grievance logs from April 2025 to March 2026 showed that no grievances were filed on behalf of the Resident Council from April 2025 to December 2025. Further review of the log revealed grievances filed on behalf of Resident Council in January 2026, February 2026, and March 2026 had no documentation of complaints/grievances, plans to resolve the complaints/grievances or actions taken to resolve the complaints/grievances. The Resident Council minutes dated 4/16/25 and recorded by the Activity Director showed grievances related to housekeeping, dietary, and nursing services. Housekeeping concerns included bathrooms that were not consistently cleaned, delayed trash removal, and slow laundry services. Dietary grievances included missing tray items such as utensils, condiments, and napkins; incorrect or incomplete meals; and unavailable alternatives. Nursing concerns included delayed response to emergency call lights and nursing assistants being hesitant to assist across halls. Residents #5, #15, #79 and #90. Resident #90 was the Resident Council President. The Resident Council minutes dated 5/13/25 and recorded by the Activity Director showed ongoing housekeeping concerns with inconsistent room cleaning and delays in receiving basic supplies like toilet paper and paper towels. Dietary grievances included missing tray items such as utensils, condiments, and napkins, and incorrect or incomplete meals. Nursing concerns included lack of communication regarding medication changes. The minutes did not show the facility's response to grievances voiced during the previous Resident Council meeting. Residents #5, #15, #62, #79 and #90 attended this meeting.The Resident Council minutes dated 6/10/25 and recorded by the Activity Director showed ongoing dietary grievances, with residents reporting meals as cold, bland, inconsistently prepared, and lacking variety. Housekeeping concerns included incomplete room cleaning, ongoing delays in laundry services, and residents needing to repeatedly request cleaning. The minutes did not show the facility's response to grievances voiced during the previous Resident Council meeting. Residents #5, #15, #33, #79 and #90 attended this meeting.The Resident Council minutes dated 7/15/25 and recorded by the Activity Director showed continued dietary concerns, including poor food quality, inconsistent preparation, and unresolved complaints. Nursing concerns included nursing assistants' reluctance to assist with resident needs and unprofessional attitudes. Housekeeping concerns included ongoing laundry delays and a lack of a consistent room cleaning schedule. The minutes did not show the facility's response to grievances voiced during the previous Resident Council meeting regarding inconsistently prepared meals and delays in receiving items back from the laundry.The Resident Council minutes dated 8/12/25 and recorded by the Activity Director showed ongoing concerns in both nursing and housekeeping services. In nursing, residents reported that some nurse aides were unwilling to remove soiled briefs from trash cans, and negative attitudes from certain staff members. In housekeeping, concerns were noted regarding bathrooms not being consistently stocked with toilet paper. Residents also expressed a desire for quicker follow-up on concerns in general. The minutes did not show the facility's response to grievances voiced during the previous Resident Council meeting. Residents #5, #15, #33, #79 and #90 attended this meeting.The Resident Council minutes dated 9/09/25 and recorded by the Activity Director showed concerns with staff disposing of used briefs in resident trash cans and did not show the facility's response to grievances voiced during the previous Resident Council meeting. Residents #5, #15, #79 and #90 attended this meeting.The Resident Council minutes dated 10/14/25 and recorded by the Activity Director showed ongoing nursing grievances, including nurse aides leaving soiled briefs in resident trash cans, medication accuracy, and poor staff attitudes. The Old Business section of the minutes revealed last month's concerns were reviewed and updates were (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided by department heads. There was no documentation showing the updates, and the minutes indicated there were no staff members or visitors invited by the Resident Council present. Residents #15, #79 and #90 attended this meeting.The Resident Council minutes dated 11/11/25 and recorded by the Activity Director showed under Old Business that nursing had addressed the issues of nurse aides throwing briefs on the floor instead of properly disposing of them, medication accuracy and negative staff attitudes and medication timeliness. There were concerns regarding shower schedules not being followed and showers being missed. There was no documentation showing the facility's response to the nursing grievances. Residents #15, #79 and #90 attended this meeting.The Resident Council minutes dated 1/13/26 and recorded by the Activity Director showed ongoing concerns with staff attitudes, soiled briefs left in resident trash cans, and medication accuracy. There were also concerns regarding missing personal belongings, inconsistent showers and call lights not being answered in a timely manner. The minutes indicated there was no Old Business, as the December 2025 meeting was conducted by corporate staff and no minutes were recorded. There was no documented follow-up from the grievances voiced at the November 2025 meeting. Residents #5, #15, #79 and #90 attended this meeting. The Resident Council minutes dated 2/12/26 and recorded by the Activity Director showed under Old Business that all concerns had been documented and forwarded to the appropriate departments for review and resolution. The concerns included missing personal belongings, inconsistent showers, staff attitudes, medication accuracy, dirty briefs being left in trash cans and call lights not being answered in a timely manner. There was a new concern with staff being on their phones during work hours. There was no documentation showing the facility's response to the Old Business concerns. Residents #5, #15, #68, #79 and #90 attended this meeting. The Resident Council minutes dated 3/10/26 and recorded by the Activity Director showed dietary concerns related to inconsistent portion sizes and nursing concerns regarding excessive noise from night shift staff. The status update for Old Business read Resolved, with no further documentation provided. Residents #5, #15, #33, #68, #79, #87, #89 and #90 attended this meeting.A Resident Council meeting was conducted on 4/01/26 at 2:01 PM with Residents #5, #15, #33, #43, #62, #68, #79, #80, #87, #89 and #90 (Resident Council President) in attendance. Residents #15, #42, #79, #87 and #90 agreed the Resident Council was never provided with information regarding what was being done to address their concerns during the Resident Council meetings, nor were they provided any written communication. Residents #5, #15, # 42, #80, #87 and #90 agreed during a discussion of unresolved grievances they felt like they were being ignored and their voices didn't matter. The group indicated they raised the same concerns in each meeting and found it frustrating that there was no follow-up or resolution. An interview on 4/02/2026 9:57 AM with the Activity Director revealed she organized the Resident Council meetings and took the minutes each month. She indicated the meetings would include reviewing resident rights, the previous month's business, upcoming events and current concerns. The Activity Director revealed she provided updates and resolutions regarding concerns from the previous month during the meeting under Old Business. She noted when grievances were voiced, they were documented in the meeting notes and communicated verbally to the appropriate department heads and to the Social Service Manager. The Activity Director indicated the Social Service Manager also received a copy of the Resident Council minutes each month and would verbally inform her when issues had been resolved, which she then shared at the next Resident Council meeting. She revealed no written documentation of investigations or outcomes had ever been provided to her, and in December 2025 the grievance process changed so that information was documented on formal grievance forms. The Activity Director indicated the Social Service Manager completed the grievance forms based on the Resident Council notes she provided. Although the Activity Director reported she no longer received updates regarding the outcomes of grievances, she noted most concerns were addressed and resolved over time. When did she stop getting updates regarding the outcomes of grievances?On 4/02/2026 at 10:34 AM an interview with the Social Services Manager revealed he was the Grievance Official for the facility. He stated that upon reviewing the Resident Council (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minutes, he would complete a formal grievance form and forward it to the appropriate department head for follow-up. The Social Service Manager explained that the process had been updated in December 2025 to include attaching Resident Council meeting minutes to grievance forms so department heads would have additional context for concerns raised. He acknowledged he had not been recording Resident Council grievances on the grievance logs but had started to do so in January 2026. The Social Service Manager reported he tracked grievance resolution by reviewing the following month's Resident Council meeting minutes and indicated that department heads attended meetings to explain their investigations, outcomes, and how issues had been resolved. However, he was unable to explain how follow-up was being conducted as the Resident Council minutes reflected no other staff had attended meetings except for the August 2025 meeting. The Social Service Manager indicated he did not receive any written notification of grievances being resolved, he reported that he considered fourteen days sufficient time to investigate and resolve an issue so that is what he recorded as a resolution date on the grievance logs. An interview on 4/03/2026 at 1:31 PM with the Administrator revealed that in December 2025 their corporate office directed the use of formal grievance forms and inclusion of Resident Council meeting minutes for follow-up and tracking. She confirmed the Social Services Manager served as the grievance official and was responsible for receiving and routing concerns to the appropriate department heads and following up with investigations. The Administrator indicated that food service concerns were part of an ongoing process and would not be resolved immediately, as improvements required time and coordination within the Dietary Department. She reported that the Dietary Department was responsible for following up on concerns and ensuring corrective actions and monitoring were completed, and the Nursing Department was responsible for following up on the nursing concerns raised. The Administrator revealed the grievance process was still being refined, with a focus on clarifying responsibilities, improving consistency, and ensuring Resident Council concerns were addressed, tracked, and resolved promptly.

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on record review and interviews with staff and Pharmacist, the facility failed to implement a system to consistently and accurately reconcile controlled medications obtained from home for 1 of 1 resident reviewed for medication management (Resident #8). As a result, a total of 31 tablets of Lorazepam (a controlled medication) were unaccounted for. The facility also failed to keep accurate records of controlled medications for 1 of 2 medication cart narcotic records reviewed.The findings included:

1.Resident #8 was admitted to the facility 1/9/26 for a respite stay with diagnoses that included anxiety disorder.

Resident #8 had the following physician's orders for Lorazepam:

1/9/26 - Lorazepam oral tablet (benzodiazepine) one (1) milligram (mg) – give one tablet by mouth every 8 hours as needed for anxiety. This order was changed on 1/12/26 to Lorazepam oral tablet one (1) mg – give one tablet by mouth every 8 hours as needed for anxiety for 14 days.

The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was moderately cognitive impaired and received antianxiety medications.

The Medication Administration Record (MAR) for January 2026 for Resident #8 indicated he received Lorazepam one (1) mg as needed for anxiety on 1/10/26, 1/11/26, 1/12/26, 1/15/26, 1/16/26, 1/18/26, 1/19/26 and 1/22/26. Medication Aide (MA) #1 signed that she administered Lorazepam to Resident #8 on 1/10/26 at 12:00 PM and 1/11/26. Nurse #11 signed that she administered Lorazepam to Resident #8 on 1/10/26 at 8:55 PM. Nurse #12 signed that she administered Lorazepam to Resident #8 on 1/18/26.

A review of the sign-out sheet for Resident #8's Lorazepam one (1) mg tablets indicated it was initially received on 1/9/26 with 152 pills inside the bottle as counted by MA #1 and the Director of Nursing. The dose recorded on the MAR for 1/19/26 was not documented on the sign-out sheet and there were two doses documented on the sign-out sheet for 1/11/26 at 9:00 PM and 1/13/26 that were not recorded on the MAR. The ending count on the sign-out sheet was 142 pills after the last Lorazepam tablet was signed out on 1/22/26.

On 1/25/26, a discharge with return anticipated MDS assessment indicated Resident #8 was discharged to the hospital.

A phone interview with Nurse #7 on 4/1/26 at 12:52 PM revealed she had counted the controlled medications with the night shift nurse on the morning of 2/2/26 when she discovered that Resident #8 had 31 missing Lorazepam tablets. Nurse #7 stated that Resident #8 was at the hospital at that time, but he had a bottle of Lorazepam tablets in the narcotic drawer of the medication cart. Nurse #7 further stated that the bottle of Lorazepam tablets came from home because Resident #8 initially came to the facility for a respite stay. She shared that there was a sign-out sheet for Resident #8's Lorazepam but there was a discrepancy in the count, and 31 Lorazepam tablets were unaccounted for. Nurse #7 stated that she reported this immediately to the Director of Nursing.

An interview with Medication Aide (MA) #1 on 4/1/26 at 10:29 AM revealed she remembered getting
(continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	questioned about Resident #8's missing Lorazepam tablets. MA #1 stated she had given Resident #8 two tablets out of his bottle of Lorazepam tablets, and she signed them out on the sign-out sheet. MA #1 stated that when Resident #8 was first admitted to the facility, the nurses and medication aides were counting his controlled medications. MA #1 stated that when Resident #8 went to the hospital, his bottle of Lorazepam tablets was kept in the narcotic drawer of the medication cart, but they had not been consistently counting them at each shift change. MA #1 stated that they should have been counting all the controlled medications in the medication cart regardless of whether they came from the pharmacy or from home. A phone interview with Nurse #11 on 4/8/26 at 4:49 PM revealed she had given Resident #8 a dose of Lorazepam on 1/10/26 at 8:55 PM which she obtained from his bottle of Lorazepam tablets. Nurse #11 stated that she did not count the Lorazepam pills in the bottle while Resident #8 was in the hospital because it was taped shut with two signatures on the bottle. Nurse #11 stated she could not remember whose signatures they were. She further stated that since Resident #8 was in the hospital, they did not have a reason to count the Lorazepam pills especially a big bottle with over a hundred pills. Nurse #11 also stated that she did not know how it was realized that the Lorazepam count was off and she was not certain when the pills went missing. A phone interview with Nurse #12 on 4/8/26 at 5:01 PM revealed she had given Resident #8 a Lorazepam tablet on 1/8/26 and she had signed it out on the sign-out sheet. Nurse #12 stated that she couldn't speak for everyone, but she always counted Resident #8's Lorazepam pills when she had that medication cart. Nurse #12 stated that she had gone on vacation and after she came back, she heard about Resident #8's missing Lorazepam pills. During an interview with the Director of Nursing (DON) on 4/1/26 at 2:37 PM, the DON reported that Nurse #7 informed her on 2/2/26 of missing Lorazepam tablets for Resident #8. The DON stated she removed the medication bottle, verified its contents, and noted that although it contained over 100 tablets, 31 tablets were unaccounted for. The DON stated that she started an investigation and interviewed all the nurses and medication aides who had worked on that medication cart. The DON stated she checked with each one when it was counted last, but she was unable to narrow down to a specific staff member when the pills went missing. The DON stated that she found out that not everyone had been counting the Lorazepam tablets belonging to Resident #8 because he was in the hospital and it was a big bottle of pills. She also stated that she asked the pharmacy to replace the missing pills and bill the facility for them. The DON stated that there were only 10 doses signed out on the sign-out sheet. A phone interview with the Pharmacist on 4/1/26 at 3:58 PM revealed they had filled 31 Lorazepam tablets for Resident #8 on 2/6/26 per request from the DON not to use insurance and to charge them to the facility. The Pharmacist stated that they always sent a sign-out sheet with each controlled substance they dispensed, and the nurses were supposed to be counting the controlled medications at each shift change. The Pharmacist clarified that if the medication came from home, the facility should have had enough blank sign-out sheets they could use to sign out those controlled medications. An interview with the Administrator on 4/3/26 at 1:40 PM revealed Resident #8's missing Lorazepam tablets were due to not all staff counting the tablets in the bottle because there were a lot of pills in the bottle. The Administrator stated they found out about this after the DON interviewed all the nurses and medication aides who worked on the medication cart where Resident #8's Lorazepam pills were stored. The Administrator stated that they needed to put some tighter controls on how medications (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from home were handled to keep this from happening again. The Administrator stated Resident #8's Lorazepam bottle was labeled to have 90 tablets in it, but when they admitted Resident #8 to the facility, the bottle contained more than 90 tablets. The Administrator stated that they should not have accepted more than 90 pills from home, and they should have counted out what was in the bottle and sent the rest home. 2. On 4/01/26 at 11:35 AM, observation was made of the A-Hall medication cart narcotic drawer and records. The narcotic drawer contained 38 medication cards/liquid narcotic medication and there were 38 Utilization Sheets (record of an individual resident's narcotic prescription including when doses were given, and how many doses remained). The Inventory Sheet (record of the total number of medications in the narcotic drawer at shift change which included date, time, nurse signatures, number of medications and number of Utilization Sheets) entry on 3/31/26 at 7:00 PM showed a count of 33 medication cards/liquid narcotic medication and 33 Utilization Sheets. In the space after the 3/31/26 at 7:00 PM entry on the Inventory Sheet, an additional undated entry was observed at 11:00 PM indicating a count of 33 medication cards/liquid narcotic medication and 33 Utilization Sheets. In the space after the undated 11:00 PM entry, there was no record of a narcotic count completed for the shift change on 4/1/26 at 7:00 AM. A review of the A-Hall pharmacy delivery record of controlled substances with a date of 3/31/26 and document time stamp of 8:22 PM, was cosigned as received by Nurse #10 and revealed delivery of 5 medication cards/liquid narcotic medication: Morphine Sulfate 20 milligrams per milliliter (mg/ml), one 30 ml bottle for Resident #40 Lorazepam 0.5 mg tablets, one medication card of 30 tablets for Resident #40 Hydrocodone-Acetaminophen 5 mg-325 mg, three cards of 30 tablets totaling 90 tablets for Resident #88 During an interview with the A-Hall nurse who was Nurse #9 on 4/01/26 at 11:36 AM, she stated at 7:00 AM on 4/1/26 she and the off-going night nurse, (Nurse #10) had counted all the narcotic medications in the A-Hall medication cart narcotic drawer and there had been a corresponding Utilization Sheet for each medication. Nurse #9 revealed she and Nurse #10 had not counted the total number of Utilization Sheets to realize the number of medications for 4/1/26 at 7:00 AM should have been 38 to account for the 5 medication cards/liquid narcotic medication from the night pharmacy delivery added to the 11:00 PM count of 33. She further explained that the count on 4/1/26 at 7:00 AM must have been recorded on a different page of the Inventory Sheets. During the interview, additional observation of the A-Hall narcotic records with Nurse #9 revealed an Inventory Sheet with entries dated 3/22/26, 3/23/26, 3/24/25, 3/25/26, and 4/1/26. The 4/1/26 entry was untimed and signed by Nurse #10 as the off-going nurse. The space for the on-coming nurse was not signed. The medication count indicated 37 and the Inventory Sheet count indicated 37. Nurse #9 revealed that this was the count she and Nurse #10 had done that morning on 4/1/26 at 7:00 AM and she had not signed as the on-coming nurse because she was out of sorts and was going to go back and do it. Nurse #9 explained the count of 37 on the 4/1/26 untimed entry was the total of 32 from the 3/25/26 untimed entry and the 5 medication cards/liquid narcotic medication delivered overnight to make 37 but realized now that this was not correct. Observation made of the previous entry prior to the 4/1/26 untimed entry revealed an untimed entry dated 3/25/26 with a prescription count of 32 and an Inventory Sheet count of 32 and contained the following information in the Medications Added column: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Morphine Sulphate for Resident #40 - 1 Lorazepam for Resident #40 - 1 Hydrocodone-Acetaminophen for Resident #88 – 3 A telephone interview was conducted with Nurse #10 on 4/2/26 at 3:37 AM. Nurse #10 stated she was the A-Hall nurse on night shift the night of 3/31/26 at 11:00 PM into 4/1/26 at 7:00 AM. She revealed she had taken delivery of 5 narcotic medications (four medication cards and one bottle of liquid morphine) delivered from pharmacy overnight and had written them on the A-Hall Inventory Sheet and had updated the count by 5. Nurse #10 did not recall if her entry of the delivered medications was on the 3/31/26 at 11:00 PM entry line. Nurse #10 explained that she and the on-coming nurse (Nurse #9) had counted at 7:00 AM and Nurse #10 had documented the count on the Inventory Sheet. Nurse #10 also did not recall having put the 4/1/26 at 7:00 AM count entry in the space after the 3/25/26 untimed entry. Nurse #10 stated she had also worked on C-Hall on 3/31/26 and left to go to that hall to give report and did not see if Nurse # 9 signed the Inventory Sheet. On 4/1/26 at 12:29 PM an interview was conducted with the Director of Nursing (DON). She stated whenever the number of narcotic medications did not match the number on the Inventory Sheets that nurses and medication aides should have investigated why they did not match. She explained nurses and medication aides were trained to call the DON if they had not been able to reconcile the number of medications with the Inventory Sheets and the Utilization Sheets. The DON explained that narcotic shift change counts should have been dated and timed and the off-going and on-coming nurses or medication aides should have signed indicating the medications, Inventory Sheets, and Utilization sheets all matched. The DON further explained when the Nurse #9 and Nurse #10 had counted and seen there was a medication for every Utilization Sheet in the narcotic binder and they probably thought it was alright when in fact they had not added the 5 newly delivered medication cards/liquid narcotic medication to the count number. An interview was completed on 4/2/26 at 9:25 AM with the Assistant Director of Nursing (ADON). During the interview, observation was made of the A-Hall narcotic record Utilization Sheet with dates of 3/22/26, 3/23/26, 3/24/26, 3/25/26, and 4/1/26. The ADON stated entries for 3/25/26 and 4/1/26 on this page were incorrect with two missing times, a missing signature, missing strengths on the 5 medication cards/liquid narcotic medication added, and incorrect counts of the number of medications and Utilization Sheets. She explained the count of 37 on the 4/1/26 entry which she presumed to have been at 7:00 AM, should not have been added to the 3/25/26 count of 32 but should have been added to the count of 33 on the 3/31/26 entry presumed to be 11:00 PM, to make 38. The ADON further explained she and Nurse #9 had been doing a narcotic audit on 3/23/26 to review previous narcotic documentation concerns. She stated during the audit she started a new Utilization Sheet, and it may have caused confusion that she didn't cross out the remaining open spaces on the previous sheet resulting in entries not all being in chronological order. The ADON revealed Nurse #9 and Nurse #10 should have been more careful to ensure the 4/1/26 AM count was added to the correct previous count and made sure they were counting the number of Utilization Sheets to compare with the number of medications in the drawer. In a follow-up interview with the DON on 4/2/26 at 11:34 AM she explained it was never alright to adjust the narcotic count without making sure the medication count and documentation were correct. The DON stated she thought sometime staff giving meds got confused where they were supposed to write when adding and subtracting meds on the Utilization Sheets. The DON revealed they had done (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	narcotic medication education on 2/3/26 to 2/3/36 after a previous discrepancy and was not sure what went wrong here and that she planned to revisit documentation training. In an interview with the Administrator on 4/01/26 at 12:51 PM she stated the expectation was that documentation for narcotic counts should be done accurately at every shift change. She explained that not having an accurate count documented could open up the door to multiple problems including diversion and this was something they usually did not have a problem with.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record reviews, observations and staff interviews, the facility failed to follow their infection control policies and procedures for Enhanced Barrier Precautions and hand hygiene when Nurse Aide (NA) #8, Medication Aide #1 and NA #10 did not wear personal protective equipment during incontinence care and when NA #8 did not change gloves and perform hand hygiene after contact with a soiled brief. In addition, the Treatment Nurse failed to change her gloves and perform hand hygiene during wound care. This deficiency occurred for 4 of 8 staff members observed for infection control practices (NA #8, NA #10, Medication Aide #1 and Treatment Nurse).The findings included:A review of the facility's policy titled Enhanced Barrier Precautions, revised on 6/4/25, indicated:Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) by using gowns and gloves during high-contact resident care activities.High-contact activities included dressing, bathing, transferring, providing hygiene, changing linens or briefs, assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters), and wound care if deemed chronic by a medical provider or if MDRO was present.A review of the facility's policy entitled, Hand Hygiene, reviewed and revised on 11/13/25 indicated:Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table: either soap and water or alcohol based hand rub for the following procedures:After handling contaminated objectsBefore applying and after removing personal protective equipment (PPE) including glovesBefore and after handling clean or soiled dressings, linens, etc.After handling items potentially contaminated with blood, body fluids, secretions, or excretionsWhen, during resident care, moving from a contaminated body site to a clean body siteAdditional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.a. An observation of incontinence care provided to Resident #102 by Nurse Aide (NA) #8 and Medication Aide (MA) #1 was made on 3/30/26 at 1:50 PM. Resident #102 had a sign for Enhanced Barrier Precautions posted on her door. The sign indicated all healthcare personnel must wear gloves and gown for high contact resident care activities which included changing briefs or assisting with toileting. Both NA #8 and MA #1 were observed entering Resident #102's room, washing their hands and putting gloves on both hands. Neither aide put a gown on before they approached Resident #102's bed. Gowns were available at a receptacle inside Resident #102's bathroom. Both aides proceeded to unfasten Resident #102's brief while NA #8 started to clean Resident #102's front perineal area with a disposable wipe. They turned Resident #102 towards her right side. While MA #1 held on to Resident #102 who was turned towards her, NA #8 started to clean stool off Resident #102's buttocks with a disposable wipe using both hands. Without removing her gloves, NA #8 reached into Resident #102's drawer for a tube of moisture barrier cream and applied the cream to Resident #102's buttocks and on her abdominal fold. NA #8 removed the soiled brief underneath Resident #102's bottom as well as the drawsheet and placed both at the foot of Resident #102's bed. NA #8 placed a new brief and a drawsheet underneath Resident #102's bottom and then rolled her onto her back. Both aides fastened the new brief, replaced Resident #102's covers and re-adjusted her bed. NA #8 removed her glove from the left hand while she held the soiled brief and drawsheet with her gloved right hand, walked out of Resident #102's room and into the soiled utility room where she placed the soiled drawsheet in a bin and the soiled brief in the trash. NA #8 removed her glove from the right hand and proceeded to wash her hands.An interview with NA #8 on 3/30/26 at 2:32 PM revealed she was not paying attention to the sign on Resident #102's door about enhanced barrier precautions, but she should have worn a gown when she provided incontinence care to her. NA #8 stated she felt overwhelmed about being observed doing incontinence care and forgot to remove her gloves and do hand hygiene after cleaning Resident #102's stool off her buttocks. NA #8 stated that she usually removed her gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from both hands and washed her hands after she threw away the brief in the trash.An interview with MA #1 on 3/30/26 at 2:34 PM revealed she did not notice the sign on Resident #102's door about enhanced barrier precautions, but she should have worn gown and gloves when she and NA #8 provided incontinence care to Resident #102. MA #1 stated that there were supposed to be gowns and gloves available in a cart outside the resident's room, but she did not see a cart.b. An observation of incontinence care provided to Resident #102 by NA #8 and NA #10 was made on 3/30/26 at 2:20 PM. Resident #102 stated to both nurse aides who were preparing to get her out of the bed that she needed to be changed again. Both nurse aides entered Resident #102's room without putting a gown on. Resident #102 had a sign on her door for enhanced barrier precautions which indicated all healthcare personnel must wear gloves and gown for high contact resident care activities which included changing briefs or assisting with toileting. They washed their hands and put gloves on both hands. Gowns were available at a receptacle inside Resident #102's bathroom. Both nurse aides unfastened Resident #102's brief while NA #10 proceeded to clean Resident #102's front perineal area with a disposable wipe. Both aides turned Resident #102 to her left side while NA #10 grabbed another disposable wipe and cleaned Resident #102's buttocks. NA #10 removed both gloves and washed her hands while NA #8 fastened Resident #102's brief and changed her gown. NA #10 put another set of gloves on both hands and assisted NA #8 in transferring Resident #102 off the bed using a total mechanical lift. After positioning Resident #102 in her wheelchair, both nurse aides removed their gloves and washed their hands at Resident #102's bathroom sink.An interview with NA #8 on 3/30/26 at 2:32 PM revealed she was not paying attention to the sign on Resident #102's door about enhanced barrier precautions, but she should have worn a gown when she provided incontinence care to her.An interview with NA #10 on 3/30/26 at 2:29 PM revealed she did not see the sign on Resident #102's door about enhanced barrier precautions. NA #10 stated there was normally a cart outside the room with gowns and gloves, but Resident #102 did not have one. NA #10 stated that she knew she was supposed to wear gown and gloves when providing incontinence care to a resident on enhanced barrier precautions.c. An observation of wound care for Resident #8 by the Treatment Nurse was made on 4/1/26 at 10:54 AM. The Treatment Nurse entered Resident #8's room, washed her hands at the sink, obtained a gown from a receptacle inside the bathroom door, put the gown on and put gloves on both hands. While Resident #8 was turned towards his right side in the bed, the Treatment Nurse proceeded to remove the dressing from his pressure ulcer on the left posterior thigh and then she removed the dressing from his pressure ulcer on his left buttock. Without removing her gloves and doing hand hygiene, she obtained a disposable wipe and wiped Resident #8's left buttock. She then removed the dressing from the pressure ulcer on his right heel. The Treatment Nurse removed both gloves and without performing hand hygiene, put new gloves on. She cleaned the left posterior thigh wound with gauze moistened with wound cleanser. Without changing gloves, she wiped the left buttock wound with another gauze moistened with wound cleanser and then she wiped the right heel ulcer with another gauze moistened with wound cleanser. She then removed her gloves, washed her hands and put new gloves on. The Treatment Nurse applied calcium alginate to the left posterior thigh wound and covered it with a bordered dressing. Without changing gloves and performing hand hygiene, she proceeded to apply calcium alginate to the wound on the left buttock and covered it with a bordered dressing. She then continued to apply calcium alginate to the wound on the right heel and covered it with a bordered dressing. The Treatment Nurse tucked Resident #8's brief underneath him and placed a new brief on while turning him towards his back. She fastened Resident #8's brief and applied soft boots to both feet. She removed her gown and gloves and washed her hands in the resident's bathroom sink.An interview with the Treatment Nurse on 4/2/26 at 8:23 AM revealed she knew that she was supposed to do hand hygiene before doing wound care, after the procedure and after discarding everything used during the procedure and in between cleaning and changing the bandage. The Treatment Nurse stated that she knew she was supposed to do hand hygiene after removing gloves and before applying new gloves, but she forgot to bring a hand sanitizer with her, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was no hand sanitizer inside Resident #8's room. She also stated that she realized she should have used one glove for each of Resident #8's wounds and she should have cleaned and dressed them separately to prevent cross-contamination of the wounds.d. An observation of wound care for Resident #34 by the Treatment Nurse was made on 4/2/26 at 7:52 AM. The Treatment Nurse washed her hands, put a gown on and put gloves on both hands. She placed a barrier on Resident #34's bedside table where she put his wound supplies. She touched the trash can with her gloved hand and moved it closer to her. She removed her gloves and put new gloves on without performing hand hygiene. She then opened the dressings for Resident #34's wound care. While Resident #34 was turned towards his left side, the Treatment Nurse pulled down his brief and removed the old dressing from his pressure ulcer on his sacrum. The old dressing had moderate amount of light brown drainage. The Treatment Nurse cleaned the wound with gauze moistened with wound cleanser and then removed her gloves. Without performing hand hygiene, she put new gloves on and applied collagen to the wound bed and then covered it with a hydrocolloid dressing. She then pulled Resident #34's brief up and repositioned his pillow underneath his head. She lowered Resident #34's bed, removed her gown and gloves and washed her hands in Resident #34's bathroom sink.An interview with the Treatment Nurse on 4/2/26 at 8:23 AM revealed she knew that she was supposed to do hand hygiene before doing wound care, after the procedure and after discarding everything used during the procedure and in between cleaning and changing the bandage. The Treatment Nurse stated that she knew she was supposed to do hand hygiene after removing gloves and before applying new gloves, but she forgot to bring a hand sanitizer with her, and there was no hand sanitizer inside Resident #34's room.An interview with the Director of Nursing (DON) on 4/3/26 at 9:22 AM revealed she was also the facility's current Infection Preventionist. She stated that she placed residents with urinary catheters, feeding tubes, central lines, open wounds and residents with multi-drug-resistant organism (MDRO) in their urine on enhanced barrier precautions (EBP) and staff should be wearing PPE that included gowns and gloves when providing care to these residents. The DON stated that the purpose of EBP was to protect staff and the residents and keep infection from spreading to other residents. The DON shared that Resident #102 was on EBP because she had a wound and also had MDRO in her urine. She stated that they kept the PPE in a receptable inside the bathroom doors for each resident and she tried to educate staff where to find them. The DON stated staff sometimes did not pay attention to the EBP signs, but they should be wearing gown and gloves when taking care of residents on EBP. She stated that NA #10, MA #1 and NA #8 should have worn gown and gloves when they provided incontinence care to Resident #102. The DON also stated that NA #8 reported to her that she got flustered while being observed doing incontinence care, and that she knew what she was supposed to do. The DON stated that she hoped NA #8 would not have made the same mistake of not changing gloves and doing hand hygiene after she touched soiled items when she was not being observed. The DON also added that NA #8 should have removed her gloves and performed hand hygiene to prevent contamination of everything else in the resident's room. She also stated that the Treatment Nurse should have changed her gloves and performed hand hygiene in between doing wound care for each of Resident #8's wounds and she should have done hand hygiene each time she removed her gloves during wound care for both Resident #8 and Resident #34.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and resident and staff interviews, the facility failed to provide a functioning resident call system for 1 of 2 residents reviewed for resident call system (Residents #1).The findings included:Resident #1 was admitted on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia, cerebrovascular accident (CVA) with hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side), chronic kidney disease, and chronic pain syndrome. The Care Plan revised 2/20/26 for Resident #1 had a focus for ADL (activities of daily living) self-care performance deficit with interventions to encourage the resident to use the bell to call for assistance and required supervision by 1 staff for toileting and personal hygiene. Resident #1's quarterly Minimum Data Set (MDS) on 3/25/26 indicated she was cognitively intact with adequate hearing and vision. She was coded as no impairment for upper extremity functional mobility. An interview was conducted with Resident #1 on 3/30/26 at 2:45 PM. At the start of the interview an observation was made of Resident #1 in her wheelchair at her doorway calling for staff. She stated the call bell didn't always work and sometimes she had to yell out for someone passing by her room. When asked if she had let someone know, she replied they knew and had spoken with the aides about it multiple times. Resident #1 explained there had been times when she pushed the call bell and saw the small light on the call bell panel in her room light up yellow and if she was up in her wheelchair she could see the light next to her door in the hall hadn't lit up. She stated she had been independent her whole life and it made her anxious to have to wait for help from others. An interview was conducted on 4/2/26 at 2:56 PM with Nurse #8 who was Resident #1's nurse that shift and had worked on Resident #1's hall in recent weeks. Nurse #8 revealed she had known that Resident #1's call bell did not always light up but did not recall the date she knew. Nurse #8 explained she left a note at the receptionist's desk earlier this week to enter this into the electronic work order system because she did not know how to put work orders in the system. Nurse #8 also explained that Resident #1 had anxiety and would sometimes get anxious if no one came as soon as she wanted them and would call out. She stated the resident did not have a hand bell to ring. On 4/2/26 at 2:57 PM an observation was made of Resident #1 pushing her call bell. After she pushed the bell a small yellow light lit up on the call bell panel in her room. An immediate observation of the call bell system light in the hall on the side of the door next to Resident #1's room appeared white as if it hadn't lit up. Close observation from 3 feet away looking directly up at the light in the hall on the side of the door revealed a dim yellow color not visible from other locations in the hallway. No hand bell was observed in Resident #1's room. An interview was conducted on 4/2/26 at 3:26 PM with the Maintenance Director who stated he had been aware of the general problem with the call lights in the halls but not specific rooms except for another resident's room on another hall. He explained they had replaced the call bell panel in that other resident's room three times in the past week which did not help the hall light. The Maintenance Director revealed that if more than one light was on, the hall lights were so dim you could not see them light up yellow. He explained the call bell system functioned with sound and lights and that a bell sounded at the nurses station which could be heard on the halls, but there was no local sound associated with a specific room. He further explained there was one ceiling light for each hall and there was a light outside each resident room which lit up yellow when the call bell was pushed. The Maintenance Director stated he had been unaware that Resident #1's room on D Hall was also a problem to the point you could not see the light in the hall because it was so dim. He stated they had just given Resident #1 a hand bell and was going to have an electrician look at the system. While discussing whether there had been any work orders for call bells The Maintenance Director did not recall specific dates of work orders or how long he had known there had been a problem other than with the other resident's room within the past week. During the interview an observation was made of the Maintenance Director's work order system on his tablet which listed (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	zero pending work orders. He stated he was unable to show a work order history because they cleared from the system as they were completed. In an interview with Nurse Aide (NA) #5 on 4/2/26 at 3:40 PM, she revealed she knew Resident #1 well. NA #5 stated the call light system did work but the lights outside resident's rooms sometimes were really dim, especially on D Hall. She explained when more lights got pushed at the same time they got [NAME] to where you couldn't tell they were lit up. She elaborated that some rooms seem to get [NAME] than others and Resident #1's room was consistently one of the rooms that barely showed when pushed and if one light was reset the others would become brighter. She stated Resident #1 did not have a hand bell until maintenance had given her one today. NA #5 further explained there was a light on the ceiling at the beginning of each hall visible from the nurse's station. Staff knew a call light was going off on that hall from this ceiling light even if the light in front of the resident's room was not visible. NA #5 revealed they could not always see that ceiling light from the far end of the hall and staff would search down the hall to see who needed help. NA #5 further explained at the nurse's station there was a light control switch board that had lights with room numbers that lit up when a resident in that room pushed the call bell. She stated it usually worked maybe 90% of the time but had seen when the lights on the switchboard would not light up, especially on D Hall. NA #5 stated she had been aware of the problem with the lights for maybe a few months and did not remember putting in a work order for the call bell system because staff in general had been aware of the problem. She explained they had switched from putting paper work orders in a box to an electronic work order system sometime last fall and staff had gotten training on the system right after it had been installed. Nurse Aide #6 was interviewed on 4/2/26 at 3:46 PM. NA #6 explained she thought the call bells had been a problem for a couple months and sometimes the lights outside the resident's rooms would be too dim to see from the nurse's station. She further explained they could see each hall's ceiling light from the nurse's station to know that someone on that hall was calling. NA #6 stated you couldn't always tell which room it was, but they might see the dim light when they went to find out who it was. She revealed she hadn't put in a work order for the call bells but had used the electronic work order system maybe twice for little things like a doorknob and noticed repairs completed same day. An interview was conducted on 4/3/26 at 1:18 PM with the Administrator with the Director of Nursing present. The Administrator stated she did not know the call bell system was having problems. She explained that staff needed to put a work order in if something wasn't working and they had been trained on use of an electronic work order system that had been implemented a few months ago. She further explained that maintenance staff would let her know if there were any trends related to work orders.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and resident and staff interviews, the facility failed to provide care in a manner that maintained the resident's dignity by not providing incontinence care when needed. Resident #102 stated it made her feel bad having to wait a long time to be changed. This occurred for 1 of 3 residents reviewed for dignity (Resident #102).The findings included:Resident #102 was admitted to the facility on [DATE].The admission Minimum Data Set assessment dated [DATE] indicated Resident #102 was cognitively intact, had adequate vision, required substantial/maximal assistance with toileting hygiene and was frequently incontinent of both urine and bowel.During a continuous observation on 3/30/26 from 1:24 PM to 2:00 PM, an interview was conducted with Resident #102 who was lying in bed in her room. Resident #102's call light was not on at the start of the observation. There was a faint odor of urine and feces upon entry into Resident #102's room. Resident #102 stated that she always had to wait long to be changed. Resident #102 stated that she was incontinent of urine and stool at 11:45 AM and turned her call light on at 11:45 AM and had been waiting to be changed since then. She indicated she knew this because she looked at her cellphone and noted the time when she asked Nurse Aide (NA) #8 to change her. Resident #102 stated that NA #8 told her that she needed to get somebody to help her. Resident #102 further stated that staff probably needed to serve lunch trays first before she could be changed. Resident #102 stated that it made her feel bad having to wait a long time to be changed. Resident #102 shared that she did not usually eat breakfast or lunch. At 1:36 PM, NA #8 was observed walking up and down the hall twice without stopping at Resident #102's room.On 3/30/26 at 1:45 PM, NA #8 was interviewed and she stated that Resident #102 had asked her to change her, but she couldn't remember what time she had asked her, and she couldn't say if it was before or after lunch. NA #8 stated that she was getting ready to do her incontinence rounds soon and she would get to Resident #102 eventually during her rounds. NA #8 stated that Resident #102 wanted her to find somebody to help her because she did not like to be changed by one person. NA #8 shared that she had asked the other nurse aides, but they were all busy at that time. NA #8 could not say which staff members she had asked to assist her.At 1:50 PM on 3/30/26, NA #8 walked into Resident #102's room with Medication Aide (MA) #1 and provided incontinence care to Resident #102. Resident #102's brief was heavily soiled with urine and feces. Her drawsheet was also visibly wet underneath her brief.An interview with NA #8 on 3/30/26 at 2:18 PM revealed she did not normally work on day shift (7:00 AM to 3:00 PM) and she just picked up an extra shift today. NA #8 stated that they usually staffed the hall with one nurse aide and one nurse, and that she was working as the only nurse aide on the hall. NA #8 stated that she felt overwhelmed especially when she was observed providing incontinence care to Resident #102. NA #8 confirmed that she responded to Resident #102's call light and Resident #102 had asked to be changed but NA #8 could not say if it was before or after lunch. NA #8 stated that she told Resident #102 that she had to get another staff member to help her because Resident #102 required two staff members to provide incontinence care to her.An interview with MA #1 on 3/30/26 at 2:34 PM revealed NA #8 asked her for help with Resident #102 about five minutes before they both went in to provide incontinence care to Resident #102. MA #1 stated that NA #8 did not ask her for help prior to that.An interview with NA #9 on 3/30/26 at 2:08 PM revealed she was working on C hall that day and that NA #8 did not ask her for help with Resident #102. NA #9 stated the rehabilitation hall where Resident #102 resided should have at least two nurse aides for residents who required two staff members to assist them. NA #9 stated it was hard to get everything done on the rehabilitation hall when there was only one nurse aide working.An interview with NA #10 on 3/30/26 at 2:29 PM revealed NA #8 did not ask her to help change Resident #102.An interview with NA #12 on 3/30/26 at 2:47 PM revealed NA #8 did not ask her for help with changing Resident #102 before lunch. NA #12 stated she remembered NA (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Ridge Health and Rehabilitation	25 Reynolds Mountain Boulevard Asheville, NC 28804

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#8 asking her for help, but it was after lunch and she was giving a shower to another resident at that time.An interview with NA #11 on 3/30/26 at 2:49 PM revealed she was working on another hall and NA #8 did not ask her for help on the rehabilitation hall.An interview with Nurse #4 on 3/30/26 at 2:31 PM revealed she was assigned to Resident #102, but she was not aware that Resident #102 had been waiting to be changed since before lunch. Nurse #4 stated NA #8 did not ask her for help with Resident #102, but she would have if she knew about it.An interview with the Director of Nursing (DON) on 3/30/26 at 4:25 PM revealed that it was not ok for Resident #102 to have waited two hours to be changed, and she told her staff to provide assistance to residents within 15 to 20 minutes maximum. She further stated that to maintain Resident #102's dignity, she shouldn't have to wait long for incontinence care especially after a bowel movement.An interview with the Administrator on 4/3/26 at 1:40 PM revealed any resident should only had to wait 10 to15 minutes maximum especially if there was bowel movement involved. She stated that the nurse aide should have asked their nurse for help. The Administrator stated that in order to maintain a resident's dignity during incontinence care, staff should provide privacy by pulling the curtain or shutting the door, and let them wait for 10 to 15 minutes at the most while immediate response was always better.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and staff interviews, the facility failed to notify law enforcement and Adult Protective Services (APS) for an initial allegation of injury of unknown origin. The facility also failed to submit a 5-day investigation report to the state agency within the required timeframe for 1 of 1 resident with an allegation of injury or unknown source (Resident #105). 1. Review of the facility policy dated 6/1/25 abuse, neglect and exploitation stated the facility was to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prevent abuse, neglect, exploitation and misappropriation of resident property.2. The procedure included:7. (A) The facility will have written procedure for reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (law enforcement when applicable) within specified timeframes. A. Immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury. B. Not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury.7. (B) The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.Review of the initial allegation report (24-hour report) dated 4/20/25 revealed an allegation of injury of unknown source. The details of the report stated Resident #105 was noted during rounds to have externally rotated right leg. Resident #105 was sent to the emergency room for evaluation and treatment of externally rotated right leg. All other residents assessed with no additional findings. It was documented that law enforcement was not notified, and the report did not indicate if APS was notified. The 24-hour report was completed by the Director of Nursing (DON).Review of the investigation report dated 4/22/25 revealed staff interviews were conducted with no evidence of a fall noted. Per documentation Resident #105 ambulated on the unit unassisted with unsteady gait at times. Skin assessments showed no bruising or edema consistent with a fall. All other residents on the locked unit were assessed with no additional findings. The investigative report did not indicate if law enforcement or APS was notified. The investigation report was completed by the DON on 4/22/25.An email from the complaint intake unit of the state agency on 4/30/25 to the Administrator indicated that the investigation report related to the 4/20/25 initial allegation report for Resident #105 with allegation of injury of unknown source had not been received.On 4/1/26 at 2:30 pm an interview was conducted with the Director of Nursing (DON). She stated that she remembered investigating the injury of unknown source by interviewing staff and doing complete assessments of all the residents on the locked dementia unit. The DON stated she could not remember if law enforcement or if APS was notified of the investigation. The DON did not recall if the 5-day report was faxed to the state agency. On 4/2/26 at 4:15 PM an interview was held with the Administrator. She stated that back in April 2025 the facility was using efax (digital version of traditional faxing) to send out reports and she should have an email showing that she had faxed the investigation report. The Administrator searched for the efax but was unable to find it. She stated the investigation report should have been faxed to the state agency within 5 days of the initial incident, but it appeared it had not been.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and Power of Attorney, staff, Ombudsman, Hospital Case Manager and Medical Director interviews, the facility failed to allow a resident to return to the first available bed at the facility after being sent to the hospital for a medical and psychiatric evaluation. Resident #101 remained in the hospital for 11 days despite being cleared to return to the nursing home and was eventually discharged home. This deficient practice was evidenced for 1 of 3 residents reviewed for transfer and discharge (Resident #101).The findings included:Resident #101 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, post-traumatic stress disorder (PTSD), bipolar disorder, delusional disorders and cataract.A review of a Change in Condition form for Resident #101 dated 2/6/26 at 8:47 AM indicated the resident was found lying in bed with a safety razor in hand and copious amount of blood on hands, wrists and abdomen. Multiple shallow lacerations noted to bilateral wrists, bilateral antecubital (inner crook of the elbow) areas and right neck. Interventions listed were to call for 911 for an emergency medical transport.The discharge Minimum Data Set assessment dated [DATE] indicated Resident #101 had modified independence with making decisions regarding tasks of daily life and had no behavioral symptoms. Resident #101's discharge was coded as an unplanned discharge with return anticipated.A review of the hospital case manager notes for Resident #101 dated 2/6/26 through 2/17/26 indicated:2/6/26 - Patient is being referred out by Psychiatry. She has been placed into ED (Emergency Department) observation status due to this potentially taking a significant amount of time to transfer out.2/10/26 - The case manager discussed with nurse at rounds. It is anticipated that patient will be psychiatrically cleared soon. She is being treated for UTI (urinary tract infection) currently. The case manager called the facility to confirm if they are planning to accept her back. Spoke with the Assistant Nursing Director and she reported that they have discharged her from their facility due to a suicidal attempt. She stated that they informed her POA (Power of Attorney) of this.2/11/26 - Behavioral health cleared patient, doesn't need inpatient psychiatry. Social Work to work on placement to SNF (skilled nursing facility).2/12/26 - The case manager received call back from the Ombudsman. She is going to investigate the issues with the facility and talk with the APS (Adult Protective Services) worker.2/13/26 - The case manager called the facility to discuss with staff if patient is able to go to the facility. Left voicemail with the front desk staff requesting a call back.2/16/26 - Spoke with the Ombudsman and she stated the facility will not take patient back and she will follow up with the state on a report and recommending to call APS at discharge to make another report. The case manager and charge nurse visited patient at bedside to share results and that discharge is likely tomorrow based on no options for SNF placement. The case manager left message with patient's healthcare POA that discharge would be tomorrow, and we need her keys to get patient in the house. Asked for a callback to arrange.2/17/26 - All other SNF, ALF (assisted living facility) have declined this patient going to their facility. Reported that the facility had declined taking her back and will accept the penalty fee for this act. Patient will be set up with home health, choice provided. Will notify APS following discharge. Healthcare POA is able to meet patient at her house.Discharge note: Patient is a [AGE] year old female and she has been here for 270 hours. We have had every social worker in the hospital try to help us get a good patient plan for her. Patient is not interested in giving up her trailer. Patient is blind but has an opportunity to get cataract surgery but does not want it. We have arranged for meals on wheels, in-home health care. And also talked to her POA. We believe the safest plan is for her to return home and we are going to get her home safely. We have offered as much as we can here from this hospital.A phone interview with the Hospital Case Manager on 4/6/26 at 11:19 AM revealed Resident #101 was seen by psychiatry on 2/6/26 at the ED and was being discharged back to the facility but they refused to accept her. On 2/10/26, she spoke with the Assistant Director of Nursing (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who told her that they had discharged Resident #101 from their facility due to her suicide attempt. The Hospital Case Manager stated that she got in touch with the Ombudsman to report that the facility refused to take Resident #101 back and that she had difficulty finding another nursing facility to accept her. The Hospital Case Manager stated that she left a voicemail at the front desk at the facility on 2/13/26, but they were not great about returning phone calls. On 2/17/26, she talked to the Ombudsman who reported that the facility had declined taking Resident #101 back and would accept the penalty fee.A phone interview with Resident #101's POA on 3/31/26 at 1:06 PM revealed the nurse called her on 2/6/26 and notified her about Resident #101 being sent to the hospital because she had been given a razor and had cut herself. The POA stated that she was not told anything about Resident #101 returning to the facility, but it was her understanding that she would return to the facility when discharged from the hospital. She stated that she received a phone call on 2/16/26 from the Social Worker at the hospital to pick up Resident #101's belongings from the nursing home because she was going to be discharged home. On 2/17/26, Resident #101 was sent home because no nursing facility would accept her according to the hospital and the nursing home refused to take her back. The POA further stated that this was Resident #101's third recorded suicide attempt and the hospital had checked surrounding counties, but no nursing facility would accept her. She shared that the Hospital Case Manager told her that they were releasing her because she was not a danger to herself anymore, but the POA did not think she was stable to be released home because she lived alone, was blind and did not have anyone.A phone interview with the Ombudsman on 3/31/26 at 11:58 AM revealed the hospital called her on 2/12/26 because the facility refused to take Resident #101 back and they had a hard a time finding another nursing facility that would accept her.During a follow-up phone interview with the Ombudsman on 4/8/26 at 9:17 AM, the Ombudsman stated that after she received a phone call from the hospital on 2/12/26, the Ombudsman called the facility and left a message for the Director of Nursing to call her back, but she never got a return call. The Ombudsman stated that she did not come by to the facility because she thought there was no use in arguing with the facility staff since they had already discharged Resident #101. She further stated that when she visited the facility a couple of weeks ago, it was for her quarterly visit, and she did not mention anything to the staff about Resident #101's discharge.A phone interview with the Assistant Director of Nursing (ADON) on 3/31/26 at 1:55 PM revealed she did not get a phone call from the hospital about Resident #101 coming back. The ADON stated that they discussed at the next morning meeting after Resident #101 was sent to the hospital that a decision was made that Resident #101 was not coming back to the facility because of safety reasons. The ADON stated that Resident #101 was adamant she was going to take her own life no matter what they did. The ADON stated that she did not know if Resident #101's POA was told about Resident #101 not coming back to the facility, but that the POA came to get Resident #101's belongings and told them that she would not be returning because she was discharged to a behavioral health facility.An interview with the Social Services Manager on 4/1/26 at 11:56 AM revealed he did not know what the Administrator or the Director of Nursing said about Resident #101 returning to the facility after she was sent to the hospital. He stated that he did not know if the POA got notified whether Resident #101 could return to the facility and he did not recall discussing anything about Resident #101's discharge at the morning meeting.An interview with the Admissions Director on 4/3/26 at 10:04 AM revealed the Hospital Case Manager called the day after Resident #101 went back to the hospital asking about what happened to Resident #101 at the facility. The Admissions Director stated there was no official referral put in the system from the hospital about Resident #101 coming back to the facility. He said he did not recall any other call or conversation with hospital staff. The Admissions Director explained that the facility worked with a Central Admissions team who handled admissions and re-admissions to the facility especially complex cases such as Resident #101, and they sometimes had to check with the Regional [NAME] President of Operations before admitting or re-admitting residents with complex cases.An interview with the Director of Nursing (DON) on 4/1/26 at 2:26 PM revealed Resident #101 was accepted into (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their facility through Central Admissions, and they followed a clinical grid which indicated the facility could not meet Resident #101's needs if she came back after a suicide attempt. The DON stated they could not meet her needs at the facility and asked how she could keep her safe if she tried to kill herself. The DON stated Resident #101's POA called the facility 2/16/26 asking about Resident #101's belongings, and she did not talk to her or the ADON about Resident #101 coming back to the facility. The DON stated that she would have to look at notes about the morning meetings but ultimately, the Administrator and the Regional [NAME] President of Operations would make a decision about not allowing Resident #101 to return to the facility. The DON stated that it would have been possible that the hospital contacted Central Admissions.An interview with the Administrator on 4/3/26 at 1:40 PM revealed she did not know what Central Admissions told the hospital, but she did not deny Resident #101's readmission to the facility. The Administrator stated that she spoke with Resident #101's POA on 2/16/26 but all she said was that Resident #101 was being discharged home the next day. The Administrator stated that the POA never said anything about Resident #101 coming back to the facility. She shared that the Ombudsman came to the facility, but she did not say anything to them about Resident #101 needing a facility to discharge to. The Administrator stated that Resident #101 probably chose to go elsewhere and they did not track her any further than that.A phone interview with the Medical Director on 4/1/26 at 1:54 PM revealed Resident #101 was appropriate to be at the facility, and they could not refuse to admit her. The Medical Director stated that if Resident #101 was saying that she had no suicidal ideations, they had no leg to stand on about refusing to take her back because she won't be admitted to inpatient psychiatry if she was denying any suicidal ideation and then there was nowhere else for her to go. The Medical Director stated that she remembered speaking to facility staff about what happened to Resident #101, but she was not consulted about whether to let her return to the facility.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident with serious mental health disorders for 1 of 3 residents reviewed for PASRR (Resident #101).Findings included:A PASRR Determination Notification letter dated 9/04/25 revealed Resident #101 had a Level I PASRR with no expiration date.Resident #101 was admitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder, bipolar disorder in remission and delusional disorders. She was also diagnosed with major depressive disorder, single episode, severe with psychotic features. Resident #101's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #101's active psychiatric/mood disorder diagnoses included depression, bipolar disorder, psychotic disorder and post-traumatic stress disorder. She received antipsychotic and antidepressant medications during the MDS assessment period. An interview with the Social Worker (SW) on 4/03/26 at 9:24 AM revealed he was responsible for submitting requests for Level II PASRR evaluations. He indicated Resident #101 came from the hospital with a Level I PASRR so it wasn't necessary for him to submit a request for a Level II PASRR as the hospital would have done so if they felt it was warranted based on her mental health diagnoses. The SW revealed if a resident arrived with a halted or Level I PASRR he did not review their diagnoses, but he would submit for a Level II PASRR evaluation if a new mental health diagnosis was made while the resident was living at the facility. An interview with the Administrator on 4/03/26 at 1:31 PM revealed the Admissions department should verify there was a current PASRR before a resident moved into the facility, and the Social Worker was responsible for the PASRR process beyond that. She indicated the hospital discharge information for Resident #101 did not provide a clear diagnosis of either bipolar disorder or postˆtraumatic stress disorder, which would have informed the facility whether a Level II PASRR evaluation was needed. The Administrator reported that someone at the facility should have identified Resident #101's mental health diagnoses and submitted a request for a Level II PASRR evaluation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews with residents and staff, the facility failed to provide incontinence care (Resident #102) and showers as scheduled (Resident #77) for 2 of 6 dependent residents reviewed for assistance with activities of daily living.The findings included:1. Resident #102 was admitted to the facility on [DATE] with diagnoses that included pneumonia, weakness and reduced mobility.The admission Minimum Data Set assessment dated [DATE] indicated Resident #102 was cognitively intact, had adequate vision, required substantial/maximal assistance with toileting hygiene and was frequently incontinent of both urine and bowel.Resident #102's care plan initiated on 2/24/26 indicated Resident #102 had an activities of daily living (ADL) performance deficit. Interventions included Resident #102 required maximum assistance by 1 to 2 staff for toileting. Further review of Resident #102's care plan indicated she had bladder incontinence. Interventions included change disposable briefs frequently and as needed, clean perineal area with each incontinence episode and check frequently and as required for incontinence.During a continuous observation on 3/30/26 from 1:24 PM to 2:00 PM, an interview was conducted with Resident #102 who was lying in bed in her room. Resident #102's call light was not on at the start of the observation. There was a faint odor of urine and feces upon entry into Resident #102's room. Resident #102 stated that she was incontinent of urine and stool at 11:45 AM and turned her call light on at 11:45 AM and had been waiting to be changed since then. She stated she knew this because she looked at her cellphone and noted the time when she asked Nurse Aide (NA) #8 to change her. Resident #102 stated that NA #8 told her that she needed to get somebody to help her. Resident #102 further stated that staff probably needed to serve lunch trays first before she could be changed. Resident #102 shared that she did not usually eat breakfast or lunch. At 1:36 PM, NA #8 was observed walking up and down the hall twice without stopping at Resident #102's room.On 3/30/26 at 1:45 PM, NA #8 was interviewed and she stated that Resident #102 had asked her to change her, but she couldn't remember what time she had asked her, and she couldn't say if it was before or after lunch. NA #8 stated that she was getting ready to do her incontinence rounds soon and she would get to Resident #102 eventually during her rounds. NA #8 stated that Resident #102 wanted her to find somebody to help her because she did not like to be changed by one person. NA #8 shared that she had asked the other nurse aides, but they were all busy at that time. NA #8 could not say which staff members she had asked to assist her.At 1:50 PM on 3/30/26, NA #8 walked into Resident #102's room with Medication Aide (MA) #1. Both aides washed their hands and applied gloves. They proceeded to pull Resident #102's cover down and unfastened the resident's brief while NA #8 started to clean Resident #102's front perineal area with a disposable wipe. They turned Resident #102 towards her right side. While MA #1 held on to Resident #102 who was turned towards her, NA #8 started to clean stool off Resident #102's buttocks with a disposable wipe. There was dried feces stuck to Resident #102's buttocks and Resident #102's brief was heavily soiled with urine and feces. Her drawsheet was also visibly wet underneath her brief. An observation of Resident #102's bottom revealed no red or open areas after NA #8 cleaned it. NA #8 removed the soiled brief underneath Resident #102's bottom as well as the drawsheet. NA #8 placed a new brief and a drawsheet underneath Resident #102's bottom and then rolled her onto her back. Both aides fastened the new brief, replaced Resident #102's covers and re-adjusted her bed. An interview with NA #8 on 3/30/26 at 2:18 PM revealed she did not normally work on day shift (7:00 AM to 3:00 PM) and she just picked up an extra shift today. NA #8 stated that they usually staffed the hall with one nurse aide and one nurse, and that she was working as the only nurse aide on the hall. NA #8 stated that she felt overwhelmed especially when she was observed providing incontinence care to Resident #102. NA #8 confirmed that she responded to Resident #102's call light and Resident #102 had asked to be changed but NA #8 could not say if it was before or after lunch. NA #8 stated that she told Resident #102 that she had to get another staff member to help her (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because Resident #102 required two staff members to provide incontinence care to her.An interview with MA #1 on 3/30/26 at 2:34 PM revealed NA #8 asked her for help with Resident #102 about five minutes before they both went in to provide incontinence care to Resident #102. MA #1 stated that NA #8 did not ask her for help prior to that.An interview with NA #9 on 3/30/26 at 2:08 PM revealed she was working on C hall that day and that NA #8 did not ask her for help with Resident #102. NA #9 stated the rehabilitation hall where Resident #102 resided normally had one nurse aide, but they should have at least two nurse aides for residents who required two staff members to assist them.An interview with NA #10 on 3/30/26 at 2:29 PM revealed NA #8 did not ask her to help change Resident #102.An interview with NA #12 on 3/30/26 at 2:47 PM revealed NA #8 did not ask her for help with changing Resident #102 before lunch. NA #12 stated she remembered NA #8 asking her for help, but it was after lunch and she was giving a shower to another resident at that time.An interview with NA #11 on 3/30/26 at 2:49 PM revealed she was working on another hall and NA #8 did not ask her for help on the rehabilitation hall.An interview with Nurse #4 on 3/30/26 at 2:31 PM revealed she was assigned to Resident #102, but she was not aware that Resident #102 had been waiting to be changed since before lunch. Nurse #4 stated NA #8 did not ask her for help with Resident #102, but she would have if she knew about it.An interview with the Director of Nursing (DON) on 3/30/26 at 4:25 PM revealed Resident #102 did not like to be disturbed until after noon. She did not eat breakfast, and she had staff try to coordinate care for her before noon or right after. The DON stated Resident #102 always complained that she had to wait two hours to get changed, but she was not aware that it had happened today. The DON stated that it was not ok for a resident to wait long to be changed, and she told her staff to provide assistance to residents within 15 to 20 minutes maximum. She further stated that NA #8 should have asked another staff member to help her provide incontinence care to Resident #102. 2. Resident #77 was admitted to the facility on [DATE] (Wednesday) with diagnoses including non-pressure chronic ulcer on left lower leg.Resident was assigned to room [ROOM NUMBER] and was put on the shower sheet to receive showers on Saturday and Wednesday during the dayshift (7:00 AM until 7:00PM).The admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #77 was cognitively intact. She did not display any behaviors. Resident #77 was supervision or touch assistance for her shower/bathing. The Staff Assessment of Daily and Activity Preferences indicated the resident preferred showers.On 3/30/26 at 3:32 PM an interview and observation was made with Resident #77. She stated that she was admitted to the facility last Wednesday (3/25/26). Resident #77 was observed to have very oily and unkempt hair. Resident #77 was asked if she had received a shower since her admission and she stated no. Resident #77 went on to say that on Saturday, 3/28/26, a Nurse Aide (NA #1) came to her room sometime between breakfast and lunch and asked her if she wanted a shower. Resident #77 informed NA #1 that she would like to have a shower. Resident #77 stated NA #1 never came back to give her a shower. Resident #77 was able to describe NA #1.On 3/31/26 at 2:32 PM an interview was held with the NA #1 who was assigned to Resident #77 on Saturday 3/28/26. NA #1 stated she was working on Resident #77's hall from 7:00 am to 3:00 pm as a Nurse Aide. NA #1 stated she then left the facility at 3:00 PM and returned at 7:00 PM and worked as a Medication Aide on a cart from 7:00 PM until 11:00 PM. NA #1 first stated that she did not have a conversation with Resident #77 regarding a shower. When NA #1 was informed that Resident #77 stated NA #1 did ask her about receiving a shower. NA #1 then stated that she had a conversation with Resident #77, but it was in the evening when she was on the medication cart. NA #1 indicated she asked Resident #77 if she wanted a shower, but since she was on the medication cart she could not do a shower for her. NA #1 explained she asked the NA on the evening shift to shower the resident. NA #1 stated that Resident #77's shower days were assigned for Saturday and Wednesday. The NA stated that if Resident #77 would like a shower today she would be able to give her a shower around 3:30 PM.On 4/1/26 at 9:00 AM an interview was held with a Nurse #1. Nurse #1 stated she had been assigned to the rehabilitation hall and was on the medication cart from 7:00 AM until 7:00 PM on 3/28/26. She stated NA #1 was the NA assigned to the floor and would have been responsible for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER: Emerald Ridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doing any showers. Nurse #1 thought NA #1 left at one point and came back to take the medication cart at 7:00 PM.On 4/1/26 at 4:55 PM a second interview and observation was completed with Resident #77 and Resident #77 was still observed with oily hair. Resident #77 was asked again about when NA #1 had asked her about wanting a shower on 3/28/26. Resident #77 again stated it was sometime between breakfast and lunch. Resident #77 was asked if it could have been in the evening when NA #1 asked her about a shower and she stated that it was not in the evening. Resident #77 stated that the NA assigned to her today (Wednesday) was unable to give her a shower. The Resident indicated NA #2 told her that she would give her a shower but did not come back until later in the afternoon and told Resident #77 she had to leave in 15 minutes so she would not have time to do the shower, but she would let the next shift NA (NA #7) know and she would be able to do her shower.On 4/2/26 at 11:00 AM an interview was held with NA #2. NA #2 stated she was assigned to Resident #77 yesterday (4/1/26) from 7:00 AM until 3:00 PM and offered her a shower, but Resident #77 stated she was in pain and wanted to get some pain medication first. NA #2 informed the nurse about Resident #77 needing pain medication. NA #2 indicated came back about 15 minutes later and Resident #77 stated she still had pain. NA #2 stated she waited for another 15 minutes, and Resident #77 stated she still had pain. NA #2 informed Resident #77 that she would not have enough time to do a shower since it would be the end of her shift and explained to Resident #77 that NA #7 could do it.On 4/2/26 at 10:50 AM a third interview was held with Resident #77, and she stated that she still had not been given her shower. The evening NA on 4/1/26 (NA #7) told her that she did not have enough time to give her a shower.On 4/2/26 at 11:29 AM an interview was held with the Director of Nursing (DON) regarding Resident #77 being admitted on [DATE] and was assigned to showers on Saturday and Wednesday and on both days the assigned NAs had not given her a shower. The DON stated Resident #77 should have had showers, and she would look into it. The DON indicated she would expect residents to get showers on their shower days and times, and if staff were unable to provide a shower, then they would inform the next shift or they would get a shower the next day.On 4/2/26 at 3:00PM a fourth interview and observation was made with Resident #77. She stated that her assigned NA today had taken her to the shower room to get a shower and washed her hair. Resident #77 still had damp hair and stated she felt much better.On 4/2/26 at 4:27 PM an interview was held with the Administrator. She stated the expectation would be for the residents to get a shower on their assigned shower days.