STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345303	A. BUILDING _____ B. WING _____	05/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431	*The Laurels of Green Tree Ridge requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is June 23, 2011. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.* **F 431** The Facility will continue to ensure that vials of insulin are properly secured. Licensed Nurse # 1 and Licensed Nurse # 2 were in-serviced on the facility's expectation for properly securing vials of insulin. All other medication carts were checked and no other issues were identified.	6/23/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard C. Stevenson — TITLE: Administrator — (X6) DATE: 6/19/2011

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.

RECEIVED
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BY: MH

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F 431	Continued From page 1 Based on observations and staff interviews, the facility failed to properly secure vials of insulin on two (2) of five (5) medications carts while the carts were left unattended. (300 Hall and 400 Hall Medication Carts) The findings are: 1. On 05/24/2011 at 3:56 p.m. observations were made of the 400 Hall Medication Cart. Observed on top of the medication cart was a plastic bin which contained six (6) plastic prescription bottles. Each prescription bottle contained a vial of insulin. Licensed Nurse (LN) #1, who was responsible for the 400 Medication Cart, was in a resident's room passing medications and the insulin vials were left unattended. LN #1 returned to the medication cart at 3:57 p.m., removed her gloves, and walked into another residents room to wash her hands. The insulin vials were again left unattended on top of the medication cart. LN #1 was observed to pass medications to two more residents, each time leaving the insulin vials unattended on top of the medication cart while she was in the resident's room. One family member was observed to walk by the cart while the insulin was left unattended. No residents were observed in close proximity to the cart while the insulin was left unattended. On 05/24/2011 at 4:11 p.m. observations were made of the 300 Hall Medication Cart. Observed on top of the medication cart was a plastic bin which contained five (5) plastic prescription bottles. Each prescription bottle contained a vial of insulin. LN #2, who was responsible for the 300 Hall Medication cart, was in a resident's room passing medications and the insulin vials were	F 431	The Licensed Nurses will be in-serviced on securing medications when not in the direct vision of the nurse by the DON/designee. A QA monitoring tool will be utilized to ensure ongoing compliance by the unit manager/designee to randomly observe the medication carts 2x daily x 2 weeks then 3x week for 2 weeks then randomly x 1 month. Variances will be corrected at the time of observation and additional education and/or administrative action taken when indicated. Observation results will be reported to the Director of Nursing weekly for the next 2 months and concerns will be reported to the Quality Assurance Committee during the monthly meeting. Continued compliance will be monitored through random medication cart observations and through the facility's Quality Assurance Program. Compliance will be monitored by the QA committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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F 431	Continued From page 2 left unattended. LN #2 returned to the cart at 4:15 p.m. One staff member was observed to walk by the cart while the insulin was left unattended. No residents were observed in close proximity to the cart while the insulin was left unattended. On 05/26/2011 at 8:45 a.m. an interview with the Director of Nursing (DON) revealed it was the facility's policy to keep insulin refrigerated when not in use. She stated that the licensed staff pull the insulin out of the refrigerator before medication pass and lock them in the cart to allow them to warm up so they were not too cold to administer. She stated the insulin was returned to the refrigerator after the medication pass was completed. The DON stated it was her expectation for the insulin vials to be locked in the cart unless they were being drawn up for administration. On 05/26/2011 at 12:45 p.m. an interview with the Administrator revealed it was his expectation for the insulin to be locked up unless in use. 2. On 05/26/2011 at 4:47 p.m. observations were made of the 400 Hall Medication Cart. Observed on top of the medication cart was a plastic bin which contained 5 plastic prescription bottles. Each prescription bottle contained a vial of insulin. At 4:52 p.m. LN #2, who was responsible for the 400 Hall Medication cart, was observed to walk down the hallway to the 100/200 Halls. The insulin vials were left unattended. One family member was observed to lean up against the cart, one resident was seated in a wheelchair within 10 feet of the cart, and multiple staff members walked past the cart while the insulin	F 431		

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F 431	Continued From page 3 was left unattended. LN #2 returned to the cart at 4:57 p.m. On 05/26/2011 at 8:45 a.m. an interview with the Director of Nursing (DON) revealed it was the facility's policy to keep insulin refrigerated when not in use. She stated that the licensed staff pull the insulin out of the refrigerator before medication pass and lock them in the cart to allow them to warm up so they were not too cold to administer. She stated the insulin was returned to the refrigerator after the medication pass was completed. The DON stated it was her expectation for the insulin vials to be locked in the cart unless they were being drawn up for administration. On 05/26/2011 at 12:45 p.m. an interview with the Administrator revealed it was his expectation for the insulin to be locked up unless in use.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	The facility will continue to ensure that hand hygiene is performed by staff per facility policy Nursing Assistant #1 was in-serviced on the facility's policy/expectation for hand washing. All other dining areas were observed and no further issues were identified. Certified nursing assistants will be in-serviced on facility policy/expectation for hand hygiene.	6/23/11

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F 441	Continued From page 4 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, review of facility policy, and staff interviews, the facility failed to practice hand hygiene after repositioning residents and touching residents' equipment with ungloved hands while setting up resident meal trays in one (1) of four (4) areas observed during dining. The findings are: An undated facility policy on Hand Hygiene contained the following: To prevent the spread of infection the employee will wash hands before or after caring for an individual.	F 441	A QA monitoring tool will be utilized during observations by the unit manager/designees to ensure that the facility's hand hygiene policy is followed in all dining areas 3x's per day x 2 weeks, then 3x a week for 2 weeks then daily x's 1 month and randomly thereafter. Variances will be corrected at the time of observation. Observation results will be reported to the Director of Nurses weekly for the next 2 months and concerns will be reported to the quality assurance committee during the monthly meeting. Compliance will be monitored by the QA committee for 3 months or until resolved addition education/training will be provided for any issues identified. Continued compliance will be monitored through random dining observation and through the facility's Quality Assurance Program.	

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F 441	Continued From page 5 A constant observation from 11:52 a.m. through 12:03 p.m. on 05/23/11 revealed Nursing Assistant (NA) #1 was in a resident's room setting up a meal tray. Another nursing assistant requested assistance positioning the resident's roommate. NA #1 was observed touching bedding with ungloved hands to assistant with repositioning. NA #1 then returned to cutting meat on the first resident's meal tray using ungloved/unwashed hands while touching knife and fork handles on the resident's meal tray. NA #1 returned to the tray cart in the hallway and was observed removing a meal tray which she carried to another resident. NA #1 assisted this resident from his bed to a chair using ungloved/unwashed hands. She was observed touching the resident's walker and shoulder during the assist. NA #1 returned to the meal cart in the hallway, removed another tray which she carried to another resident's room. She was observed repositioning this resident's wheel chair with ungloved hands and touched his arm. NA #1 was observed cutting meat using the resident's knife and fork. NA #1 washed her hands before returning to the tray cart in the hallway. An interview with NA #1 on 05/23/11 at 12:02 p.m. revealed she washed her hands in the last resident's room because she touched his trash can as she moved it out of the way. She stated she did not wash her hands after assisting the previous two residents. NA #1 stated she should have washed her hands after contact with each resident. An interview with the Director of Nursing (DON) on 05/26/11 at 8:45 a.m. revealed direct care staff received inservices quarterly regarding hand	F 441		

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F 441	Continued From page 6 washing and yearly on infection control in general. The DON stated the facility policy is to wash hands after caring for each resident. The DON added she expected staff to follow the facility policy.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to ensure the ice scoop holder in one of one nourishment pantry used by residents and families was cleaned and sanitized as scheduled. The findings are: On 5/25/11 at 11:40 AM the blue plastic ice scoop holder in the 100/200 nourishment pantry was observed mounted on the wall. The ice scoop holder was mounted over plumbing drains but did not have holes in the bottom portion to allow water to drain. The ice scoop was stored inside with the scoop portion touching the interior bottom. The ice scoop holder was removed from the wall and (along with the Food Service Director and Maintenance Director) was observed with visible water with brown debris pooled in the bottom portion. A paper towel was used to wipe a small area of the interior bottom and brown matter was easily removed. At the time of the observation the Food Service Director stated he	F 465	The facility will continue to ensure that the ice scoop holder in the nourishment pantry is cleaned and sanitized as scheduled. The ice scoop holder identified as being unclean during survey was cleaned and sanitized immediately. All other ice scoop holders were checked and no further issues were identified. Housekeeping staff will be in-serviced on expectations and held accountable by the supervisor regarding the cleaning and sanitation of ice scoop holders. A QA monitoring tool will be utilized to ensure ongoing compliance by the housekeeping supervisor/designee to randomly check daily x1 month and then randomly weekly x's 2 months.	6/23/11

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F 465	Continued From page 7 thought it was the responsibility of third shift nursing assistants to clean the ice scoop holder. On 5/25/11 at 5:10 PM the Director of Nursing stated housekeepers were responsible for cleaning the ice scoop holder, not nursing assistants. In a follow-up interview on 5/26/11 at 8:20 AM the Director of Nursing stated about a month ago there was a change in the housekeeper who was responsible for cleaning the ice scoop holder. The Director of Nursing stated the housekeeper did not realize she was responsible for cleaning the interior portion of the ice scoop holder. The Director of Nursing stated she talked with multiple staff and the last time she could determine the interior of the ice scoop holder had been cleaned was the first week of April by the Director of Maintenance. On 5/25/11 at 12:25 PM the Director of Housekeeping stated when she trained the new housekeeper (that was responsible for cleaning the ice scoop holder) she told her to wipe down everything in the nourishment room. The Director of Housekeeping stated she failed to review the procedure for cleaning the interior of the ice scoop holder with the new housekeeper. The Director of Housekeeping stated the housekeeper had only been wiping the outside of the holder and had not been cleaning the interior portion. The Director of Housekeeping stated the ice scoop holder should have been removed on a daily basis and cleaned and sanitized.	F 465	Compliance will be monitored by the QA committee for 3 months or until resolved. Additional education/training will be provided for any issues identified. Continued compliance will be monitored through random nourishment pantry checks and through the facility's Quality Assurance Program.	