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 _____	07/19/2012

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 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to send the balance of personal fund accounts to the Clerk of Courts within 30 days of the deaths of two (2) of three (3) sampled residents. Residents #35 & #244. The findings are: 1. Resident #35's medical record revealed she was admitted to the facility on 5/8/03 and expired in the facility on 5/1/12. Review of Resident #35's personal fund account managed by the facility revealed the balance of her account was not disbursed to the County Clerk of Courts until 6/14/12. Interview on 7/18/12 at 12:22 PM with the personal fund accounts manager revealed she was aware of the requirement to dispense funds within 30 days of a resident's death. Follow up interview on 7/18/12 at 3:30 PM revealed she usually balanced the resident funds account monthly and did not always know about the death of a resident until the end of the month. She stated she should have checked the daily census.	F 160	*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 August 9, 2012. 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.* The Facility will continue to ensure that residents' personal funds are conveyed within 30 days of death. The personal funds account manager was in-serviced by the Administrator on the requirements of the regulation for conveyance of personal funds upon death. All other personal funds accounts were audited and no other issues were identified. A QA monitoring tool will be utilized to ensure ongoing compliance by the BOM/designee to audit resident personal funds conveyance monthly x 3 months. Variances will be corrected as identified. Monitoring results will be reported to the Administrator monthly for the next (3) three months and concerns will be reported to the quality assurance committee during the monthly meeting.	8/9/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Hausen — TITLE: Administrator — (X6) DATE: 8/2/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 160	Continued From page 1 2. Resident #244's medical record revealed she was admitted to the facility on 12/3/09 and expired in the facility on 1/11/12. Review of Resident #244's personal fund account managed by the facility revealed the balance of her account was not disbursed to the County Clerk of Courts until 2/29/12. Interview on 7/18/12 at 12:22 PM with the personal fund accounts manager revealed she was aware of the requirement to dispense funds within 30 days of a resident's death. Follow up interview on 7/18/12 at 3:30 PM revealed she usually balanced the resident funds account monthly and did not always know about the death of a resident until the end of the month. She stated she should have checked the daily census.	F 160	Continued compliance will be monitored through random personal funds audits 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.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide incontinence care in a manner to prevent possible infections for one of one sampled resident.	F 315	The Facility will continue to ensure that incontinence care is provided in a manner to prevent possible infections. Resident #148 is receiving incontinence care per policy to prevent infection. Current residents requiring assistance with incontinence care have the potential to be affected. Nurse Aide #3 was in-serviced by the DON on the facility's policy and procedures for providing incontinence care. Nurse Aide #1 no longer works in the facility. The nurse aides will be in-serviced by the DON/designee on the facility's policy and procedure for providing incontinence care.	8/9/12

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F 315	Continued From page 2 (Resident #148). The findings are: Review of the facility's policy for Perineal Care revised June 2009 revealed all residents would receive perineal care after each incontinence episode and as needed in order to promote cleanliness, prevent infection and remove odorous secretions. The procedure for female residents included "separate labia with one hand and cleanse with the other using gentle downward strokes from front to back of the perineum to prevent intestinal organisms from contaminating the urethra." Review of the most recent significant change MDS (Minimum Data Set) dated 05/10/12 revealed Resident #148 had memory problems and was severely impaired in cognition and required extensive assistance in toilet use and personal hygiene and was always incontinent of bladder. Review of the CAAS (Care Area Assessment Summary) dated 5/17/12 documented the Resident had diagnoses of dementia with confusion, was incontinent of bowel and bladder and wore adult briefs. The summary further documented the resident had a history of UTI (Urinary Tract Infection), required extensive assistance with toileting and hygiene and was at risk for complications such as UTI. Record review revealed physician orders dated 5/22/12 for Resident #148 to begin antibiotic therapy for a UTI.	F 315	A QA monitoring tool will be utilized to ensure ongoing compliance by the Unit Manager/designee and will randomly observe incontinence care 5 times a week x 2 weeks then weekly x 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 DON 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 incontinence care 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 315	Continued From page 3 Review of the Resident's care plan dated 5/24/12 revealed interventions that included proper peri-care after each incontinence episode, keep clean and dry as possible, check frequently and change as needed. Observation on 7/18/12 at 12:25pm revealed NA (Nurse Aide) # 3 attempting to feed Resident #148 lunch but the resident was lethargic and bent over in her wheel chair. The Resident was observed at this time being transferred to bed due to being lethargic. As NA #1 and NA #3 started to assist the resident to lie down, a strong urine odor was noted. The NAs proceeded to provide incontinence care and removed the resident's brief which was saturated with dark colored urine with a strong odor. NA #3 used a wet wash cloth with soap, did not separate the labia but placed the wash cloth between the resident's legs and pulled the cloth using upward strokes, back to front. NA #3 rinsed the resident with a wet wash cloth using upward strokes back to front. When questioned regarding the last time Resident #148 had received incontinence care on 7/18/12 at 12:45 PM, NA #1 stated the Resident had last been changed that morning "maybe sometime before ten"; she could not be sure of the exact time. During an interview on 7/18/12 at 12:50 PM NA #3 stated the proper way to cleanse a female resident was front to back and stated she had not done this with Resident #148 because she was just not thinking. A nurse's note dated 07/18/12 at 1:00 PM revealed the resident had a decreased level of	F 315		

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F 315	Continued From page 4 consciousness with the urine strong smelling and dark. A follow up nurse's note at 5:45 PM, documented an in and out catheter was performed and obtained a urine specimen of small amount of thick yellowish green urine. During an interview on 7/18/12 at 2:50 PM, the Director of Nursing stated her expectations were for NAs to wipe front to back for pericare.	F 315		
F 441 SS=E	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. (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	F 441	The facility will continue to ensure that Contact Precautions are followed by staff per facility policy. Nurse Aide #2 was in-serviced by the DON on the facility's policy for Contact Precautions. Nurse Aide #1 no longer works at the facility. Current residents have the potential to be affected. No negative outcome was identified relating to these observations. The Nursing Assistants will be in-serviced by the DON/designee on the facility's policy for Contact Precautions. A QA monitoring tool will be utilized by the Unit Manager/designees during observations of care for identified residents to ensure Contact Precautions are being followed per policy 3x's per day x 2 weeks, then daily x 2 weeks then 3x per week for one month and randomly thereafter. Variances will be corrected at the time of observations and additional education and/or administrative action taken when indicated.	8/9/12

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F 441	Continued From page 5 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, record review, and staff interviews the facility failed to maintain contact precautions for 2 of 2 sampled residents on contact isolation precautions. (Resident #25 and #143). The findings are: Review of the facility's policy for contact precautions dated March 2005 revealed Contact precautions will be used for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact or indirect contact. The Procedure included wearing gloves when entering a contact isolation room, removing gloves before leaving the room and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent. The policy also included wearing gowns when entering a contact isolation room if staff clothing will have substantial contact with the resident, environmental surfaces or items in the resident's room. 1. Record review revealed Resident #143 had	F 441	Observation results will be reported to the DON 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 staff observations of Contact Precautions 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 441	Continued From page 6 tested positive for clostridium difficile (C-diff) on 7/14/12. During initial tour of the facility on 7/16/12 at 9:40 AM. Resident #143's room was observed to have an isolation cart out side the door containing gowns and gloves. A Contact Precautions sign hung on the door that included instructions to perform hand hygiene before entering and before leaving the room, wear gloves when entering room and when touching patient's skin, surfaces or articles in close proximity and wear gown when entering room and whenever anticipating that clothing will touch patient items or potentially contaminated surfaces. Observations on 7/16/12 at 12:20 PM. revealed NA #2 delivering lunch trays. NA #2 entered Resident #143's room without wearing gloves and sat the resident's tray on the over bed table. Resident # 143 handed two pieces of candy to NA #2 and dropped one piece in the floor. NA #2 picked up the candy from the floor, placed it in her uniform pocket and left the room without washing or using hand sanitizer. NA #2 proceeded to the meal cart and took another tray into another resident. During an interview 7/16/12 at 2 p.m. NA #2 stated she should have washed her hands or used hand sanitizer but just forgot. An interview was conducted on 7/18/12 at 10:20 AM. the (ICN) Infection Control Nurse. The ICN stated anytime staff were in a contact isolation room they should be gowned and gloved as they never knew when they or their clothing might inadvertently touch something of the resident's. The ICN further stated if the staff went in and did	F 441		

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F 441	Continued From page 7 not touch anything that they did not have to wear gloves but she expected them to wash their hands after leaving the room regardless. The ICN stated if an isolation sign was posted she expected staff to abide by the precautions as listed on the sign. 2. Record review revealed Resident #25 had tested positive for clostridium difficile (C-diff) on 7/11/12. During initial tour of the facility on 7/16/12 at 9:45 AM. Resident #25's room was observed to have an isolation cart out side the door containing gowns and gloves. A Contact Precautions sign hung on the door that included instructions to perform hand hygiene before entering and before leaving the room, wear gloves when entering room and when touching patient's skin, surfaces or articles in close proximity and wear gown when entering room and whenever anticipating that clothing will touch patient items or potentially contaminated surfaces. A. Observations on 7/16/12 at 12:30 PM. revealed NA (Nurse Aide) #2 delivering lunch trays. NA #2 removed a meal tray from the lunch cart and proceeded into Resident # 25's room without placing on any of the protective wear. NA #2 placed the tray on Resident #25's over bed table and positioned the table so the resident could reach the tray and left the room. The NA did not wash her hands or use hand sanitizer, proceeded to the meal cart and took another tray into another resident's room. During an interview on 7/16/12 at 2 p.m., NA #2 stated she thought she did not need to wash unless she touched the resident or something of	F 441		

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F 441	Continued From page 8 the residents. NA #2 then stated she should have worn gloves and washed her hands but just forgot. An interview was conducted with the ICN (Infection Control Nurse) on 7/18/12 at 10:20 AM. The ICN stated anytime staff were in a contact isolation room they should be gowned and gloved as they never knew when they or their clothing might inadvertently touch something of the residents. The ICN further stated if the staff went in and did not touch anything that they did not have to wear gloves but she expected them to wash their hands after leaving the room regardless. The ICN stated if an isolation sign was posted she expected staff to abide by the precautions as listed on the sign. B. Observations on 7/18/12 at 8:25 AM. revealed NA #1 coming out of Resident #25's room carrying linen. NA #1 placed the linen in the hamper for dirty linen, returned to Resident # 25's room, did not put on gloves or gown and proceeded to make up the Resident's bed. NA #1 left the resident's room without washing or using hand sanitizer. During an interview on 7/18/12 at 8:35 AM. NA #1 stated she was not sure if Resident #25 was still on isolation or not as sometimes a resident would come off precautions and the sign would be left on the door. NA #1 stated since she was using clean linen to make the bed she did not think she needed to wear gloves or a gown. An interview was conducted with the ICN (Infection Control Nurse). The ICN stated anytime staff were in a contact isolation room	F 441		

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F 441	Continued From page 9 they should be gowned and gloved as they never knew when they or their clothing might inadvertently touch something of the resident's. The ICN further stated if the staff went in and did not touch anything, they did not have to wear gloves but she expected them to wash their hands after leaving the room regardless. The ICN stated if an isolation sign was posted she expected staff to abide by the precautions as listed on the sign. The ICN stated she expected staff to wear gown and gloves when making beds of any resident who was on contact precautions because they were in contact with the bed, rails and covers and staff should wash before leaving the room.	F 441		