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 _____	C 08/22/2013

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to communicate with a resident during the provision of care for 1 of 3 residents reviewed for dignity. (Resident #1). The findings include: Resident #1 was admitted to the facility on 09/12/2008 with multiple diagnoses including closed head injury and blindness. A review of Resident #1's annual Minimum Data Set (MDS) dated 10/01/12 indicated Resident #1 was severely cognitively impaired for daily decision making skills and was totally dependent for all activities of daily living (ADL) care. The MDS further indicated the resident had severely impaired vision. Resident #1 required total assistance with all activities of daily living. According to the Care Area Assessment (CAA) dated 10/01/12 Resident #1 was able to make a few sounds and laughed and smiled when spoken to. An observation was conducted on 08/21/13 from 11:23 AM to 11:38 AM of staff caring for Resident #1. At 11:28 AM Nurse Aide #1 and Nurse Aide #2 were observed to use a total lift to transfer Resident #1 into a shower chair and took the	F 241	The Laurels of GreenTree Ridge wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is 09/17/2013. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F 241 The facility will provide care to ensure that each resident is treated in a manner that will maintain or enhance each resident's dignity. Resident #1 is receiving care in a manner and in an environment that maintains dignity and respect. Current residents have the potential to be affected. No negative outcome was identified relating to this observation. Nurse Aide #1 and Nurse Aide #2 were in-serviced by the Director of Nursing on the requirements of the regulation for dignity and respect of individuality	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Hausen — TITLE: Administrator — (X6) DATE: 9/16/13

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.

DHSR Mail Received Black Mountain MRO SEP 16 2013 by: MMH

original signature 9-13-13

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F 241	Continued From page 1 resident into the shower room and showered the resident. During the shower the resident made sounds of groaning which continued to get louder as the process continued. The shower was completed and the resident was dried off and then returned to bed and dressed. Once the resident returned to bed Vaseline was applied to his skin and deodorant was applied to his underarms. During this 15 minute observation the nursing assistants did not talk to Resident #1 at all while providing Resident #1's care. An interview was conducted on 08/21/13 at 11:54 AM with NA #2. When asked about communicating with the resident the NA stated, "I talk to him and tell him what I am going to do" . During the interview NA #2 discussed how she talked to him when she entered the room and provided the care and then would leave. When NA #2 was asked about not communicating with Resident #1 while she provided care to the resident during the morning of 08/21/13 she stated that she was just nervous. An interview was conducted on 08/21/13 at 12:01 PM with NA #1. During the interview the NA was asked about not communicating with the resident during care and she stated, "I don't talk to him as much as I should". An interview was conducted on 08/22/13 at 1:03 PM with Nurse #1. Nurse #1 discussed that Resident #1 was able to recognize his mother's voice and liked it when he heard female voices. The resident laughed and smiled when females talked to him but he didn't respond when he heard a male voice. The nurse stated she would have expected the aides to talk to Resident #1 while care was provided because the resident	F 241	which includes communicating with residents during care. All other Nurse Aides will be in-serviced by the Director of Nursing/designee on the requirements of the regulation for dignity and respect of individuality and communicating with residents during care. A QA tool will be utilized to monitor compliance by the Unit Manager/designee. The Unit Managers and designees will randomly observe staff and resident interaction and care 3 times a week x 2 weeks then weekly x 2 weeks then randomly x 1 month to ensure staff is communicating with residents during care and activities. Variances will be corrected at the time of observation and additional education provided 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 observations of care and through the facility's Quality Assurance Program.	

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F 241	Continued From page 2 liked being talked to. The nurse expressed that it was surprising that the nurse aides did not communicate with Resident #1 during care because they should have explained the procedures to the resident. An interview was conducted on 08/22/13 at 2:56 PM with the Director of Nursing (DON). The DON explained that Resident #1 did not communicate and had mannerisms like smacking his lips when he was hungry. The DON further explained that the resident laughed and smiled when staff talked to him. The DON expected staff to talk to the resident while providing care although he may not understand them. The DON described that voices comforted the resident during care. The DON stated that communicating with the resident during the provision of care is an expectation that she has for her staff.	F 241	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. The identified Nurse Aides (NA) will receive additional education regarding resident dignity and sensitivity by the DON/designee.	9/17/2013
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to prevent a significant medication error by not administering 6 scheduled doses of anti-coagulant medication as ordered for 1 of 6 residents reviewed for medication errors. (Resident #125) The findings included: Resident #125 was admitted to the facility on	F 333	F333: The facility will continue to ensure that residents are free of any significant medication errors. Resident #125 is no longer at the facility. No negative outcome resulted from the omission. Current residents have the potential to be affected. All MARs were audited between 8/27/13 and 9/2/13. All variances were corrected at the time of identification. The monthly MARs are	

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F 333	Continued From page 3 02/12/13 with diagnoses including atrial fibrillation, pulmonary edema, and cardiomyopathy. Review of the most recent annual Minimum Data Assessment (MDS) dated 02/19/13 indicated Resident #125 was cognitively intact for daily decision making and did not have memory deficits. The MDS revealed he received anti-coagulant medication for 7 days of the observation period. Review of Resident #125's medical record revealed a physician order dated 03/29/13 for Coumadin, an anti-coagulant medication, 6 milligrams (mg) to be given by mouth daily. Review of Resident 125's Medication Administration Record (MAR) for April 2013 revealed the Coumadin order had been omitted from the MAR. During an interview with the Director of Nursing (DON), on 08/21/13 at 11:08 AM she stated that Resident #125's Coumadin was not given from 04/01/13 to 04/06/13 due to an end of the month editing error on the transfer of the March MAR to the April MAR. She stated the mistake was found by Nurse #1 when she came back from vacation. The DON reported the transfer from one month to the next month of the MAR is completed by 2 nurses. The nurse that normally transfers the monthly MARs was on vacation and another nurse transferred the MAR from March 2013 to April 2013 and did not transcribe the order for Coumadin 6mg daily. The DON stated an incident report was completed and she retrained the nurse on how to change over the MAR from month to month and transcribe physician orders to the MAR. The DON stated each new nurse is trained on transcribing orders to the MAR during their new employee orientation. The DON reported	F 333	now being transcribed by at least two Licensed Nurses to ensure accuracy. The Licensed Nurses will be in-serviced by the DON/designee on the facility's procedure for transcribing physician's orders from month to month. A QA monitoring tool will be utilized to ensure ongoing compliance by the Unit Manger/designee to audit resident Medication Administration Records (MARs) monthly x 3 months. Variances will be corrected at the time of audit and additional education and or administrative action taken when indicated. Audit results will be reported to the DON monthly for the next 3 months and concerns will be reported to the Quality Assurance Committee during the monthly meeting. Continued compliance will be monitored through random MAR 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.	9/17/2013

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F 333	Continued From page 4 each medication nurse should check the new MAR against the old MAR and the physician orders each month when the new MAR is put in the book. An interview with Nurse #2 on 08/21/13 at 2:47 PM revealed she was on vacation from 04/01/13 to 04/06/13 and when she returned to work on 04/07/13 she noticed Resident #125 no longer had Coumadin on his MAR. She reported she checked the physician orders and realized the Coumadin 6mg daily ordered on 03/29/13 had not been transcribed to the MAR. Nurse #1 stated she reported this to the DON, the physician and Resident #125's family. Nurse #1 stated she did not have a formal in-service on how to transcribe and check the MAR each month after the incident and did not recall a change in the policy on how to transcribe the MAR. An interview with Nurse #3 on 08/21/13 at 7:30 PM revealed she transcribed the MAR from March 2013 - April 2013 and missed the order for Coumadin 6mg daily. She reported she only transferred MARs 2 to 3 times a year. Nurse #2 stated she was told of the mistake but did not have an in-service or training on how to transfer the MAR from month to month. She further stated she did not recall a change in policy on how to transfer the MAR each month. An interview with the Administrator on 08/23/13 at 11:30 AM revealed if a medication error occurred when transferring the monthly MARs an in-service should have been done to retrain staff on transferring MARs correctly.	F 333		