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 12/11/2014

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# NWLH11.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F 156		1/8/15

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

Electronically Signed | 01/08/2015

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F 156	Continued From page 1	F 156		

under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and

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F 156	Continued From page 2 applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to include information identifying the posted phone number of the State agency as the contact number to file a complaint. The findings included: On 12/08/14 at 9:52 AM during the initial tour of the facility, information posted on a bulletin board in a common area of the facility was reviewed. The bulletin board was covered in glass which did not prohibit reading the posted information but limited removal of the postings. Included in the information was the name and toll free phone number of the Department of Health and Human Services, Division of Facility Services. The toll free phone number was not identified as the State contact agency to file a complaint nor was the Department of Health and Human Services address included in the information. On 12/10/14 at 1:40 PM the administrator stated she was in charge of information posted on the bulletin board in the common area of the facility. The administrator reviewed posted information and stated at one time the information was included about filing a complaint with the State agency. The administrator stated she did not know what happened to the information which	F 156	The Laurels of Green Tree Ridge wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is January 8, 2015. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F156: The information posted on the bulletin board in the common area of the facility was updated at the time of observation to include the State contact agency contact number as the number to use for filing a complaint and the address for the	

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F 156	Continued From page 3 designated the Department of Health and Human Services as the agency to file a complaint or how long it had not been posted.	F 156	Department of Health and Human Services. Current residents have the potential to be affected. No negative outcome was identified relating to this observation. The Administrator/designee will provide all current residents with information identifying the phone number of the State agency as the contact number to file a complaint. A QA tool will be utilized to monitor compliance by the Administrator/designee. The Administrator/designee will randomly observe posted information monthly x 3 months to ensure accuracy and thoroughness of posted information. Variances will be corrected at the time of observation. Observation results will be reported to the Quality Assurance Committee monthly for the next 3 months. Continued compliance will be monitored through random observations of posted information 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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		1/8/15

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F 309	Continued From page 4 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administer a physician-ordered laxative for 1 of 6 sampled residents reviewed for constipation (Resident #74). The findings included: Review of the medical record revealed Resident #74 was admitted on 12/22/10 with diagnoses including dementia, aphasia and constipation. Review of a care plan dated 05/02/14 revealed Resident #74 had the potential for constipation related to impaired mobility, poor oral intake and routine narcotic use. The goal was for Resident #74 to have no unrelieved signs or symptoms of constipation. Interventions included: record frequency/characteristics of bowel movements, administer medications as ordered and document any observed signs and symptoms of constipation. A quarterly Minimum Data Set (MDS) dated 07/07/14 revealed Resident #74's cognition was severely impaired and the resident required extensive assistance with transfers and toilet use. The quarterly MDS also noted Resident #74 had	F 309	F309: The facility will continue to ensure that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident #74□s bowel movements are being monitored by the charge nurse and interventions implemented when indicated. No negative outcome resulted from the omission. Current residents with diagnoses of constipation have the potential to be affected. All bowel movement records were audited between 12/9/14 and 12/12/14. All residents with no documented bowel movement in 3 or more days were referred to the physician and laxatives administered as ordered. The bowel movement records are now being audited routinely to ensure timely	

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F 309	Continued From page 5 unclear speech and was sometimes understood. Review of Resident #74's bowel movement (BM) record from 09/11/14 through 12/10/14 revealed three episodes of no BM recorded for greater than three days: - from 09/29/14 through 10/02/14 (4 days) - from 10/09/14 through 10/14/14 (6 days) - from 11/21/14 through 11/25/14 (5 days) Review of Resident #74's monthly Physician Orders for December of 2014 revealed an order dated 07/29/12 for Senokot-S (laxative plus a stool softener) three tablets by mouth twice a day for constipation. In addition, Resident #74 had an order dated 06/11/12 for a Ducolax (laxative) suppository one rectally every three days as needed for constipation. Review of Resident #74's Medication Administration Records (MARs) for September through November of 2014 revealed the physician-ordered laxative suppository was not administered after three days without a BM during any of the three episodes of constipation. Review of nurse's notes from 09/29/14 through 11/25/14 revealed no documentation of additional BMs, three or more days without a BM or the administration of the laxative suppository for constipation. An interview was conducted with the Director of Nursing (DON) on 12/10/14 at 3:37 PM. The DON stated the nurse aides (NAs) documented resident's bowel movements in the electronic record and the nurses could access and review the information to determine if a resident had not had a BM in three days. The interview revealed	F 309	intervention. The Licensed Nurses will be inserviced by the DON/designee on the facility□s procedure for auditing bowel movement records and providing intervention as ordered or reporting to the physician as needed. A QA monitoring tool will be utilized to ensure ongoing compliance by the Unit Manager/designee. The Unit Manager/designee will randomly review all resident bowel movement records and interventions 3 times a week x 2 weeks then weekly x 2 weeks then randomly x 1 month to ensure the nurses are auditing bowel movement records, providing intervention as ordered, and/or reporting to the physician as needed. Variances will be corrected at the time of review and additional education provided when indicated. Review 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 reviews of bowel movement records 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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the facility did not have a bowel protocol or standing orders for constipation and it was the responsibility of each nurse to contact the physician for a laxative order if a resident needed a laxative and did not have a physician's order for a laxative on their MAR. The DON further stated there was no system in place designating particular staff to review resident's bowel movements but nurses were expected to review this information in the electronic record.

During an interview on 12/10/14 at 5:01 PM NA #3 stated NAs recorded their assigned resident's BMs daily in the computer charting system. NA #3 further stated NAs were not responsible for keeping track of or reporting how many days a resident went without a BM.

A follow up interview was conducted with the Director of Nursing (DON) on 12/11/14 at 9:33 AM. The DON stated nurses were expected to assess residents for signs and symptoms of constipation and document in the nursing progress notes according to the assessment schedule. The DON indicated as a general rule a resident should be evaluated for the need for a laxative after three days without a BM.

During an interview on 12/11/14 at 10:50 AM Nurse #1 stated it was her usual practice to give residents a laxative after three days without a BM. Nurse #1 explained she assessed her residents every shift and asked alert and oriented residents if they were having regular BMs. When asked specifically about Resident #74 Nurse #1 stated the assigned nurse would need to review the electronic record for no BMs in three days because Resident #74 was not always understood and had difficulty communicating due

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F 309	Continued From page 7 to her aphasia. A telephone interview was conducted with Resident #74's physician on 12/11/14 at 11:34 AM during which he stated he expected the nurse to contact either himself or the nurse practitioner when a resident went three days without a BM. The Physician noted he did not have standing orders for constipation. When asked specifically about Resident #74 the Physician stated he would have expected the nurse to administer the laxative suppository when the resident was noted as not having a BM for three days. An interview with Nurse #2 on 12/11/14 at 2:20 PM revealed he was assigned to Resident #74 but had not reviewed the electronic documentation for her last BM because she was not in the block of residents he was assigned to chart on daily.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documents and staff and student nurse aide interviews, the facility failed to provide two person transfer assistance to prevent a fall, which	F 323	F323: The facility is not in agreement with the alleged deficiency and has invoked its	1/8/15

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resulted in a fracture, for 1 of 4 sampled residents reviewed for accidents (Resident #74).

The findings included:

Review of the medical record revealed Resident #74 was admitted on 12/22/10 with diagnoses including dementia and a history of a stroke with aphasia and right hemiplegia.

Review of a significant change Minimum Data Set (MDS) dated 04/18/14 revealed Resident #74's cognition was severely impaired and required extensive assistance with transfers and toilet use.

Review of a care plan dated 05/02/14 revealed Resident #74 was at risk for fall related injury related to impaired mobility, a history of falls, confusion and possible side effects from psychotropic drug use. Interventions included assistance with all transfers.

Review of a quarterly MDS dated 07/09/14 revealed Resident #74's cognition was severely impaired and required extensive assistance with transfers and toilet use. The quarterly MDS further noted Resident #74's balance during transition while moving off and on the toilet was not steady and she was only able to stabilize balance with staff assistance.

Review of a nurse's note dated 08/02/14 at 9:40 AM revealed the nurse was informed by Nurse Aide (NA) #1 that Resident #74 was eased to the floor by Student NA #1 when her legs became weak during a transfer from the toilet to the wheelchair. The nurse was told Resident #74's right leg was bent up underneath her left leg. NA #1 and Student NA #1 had assisted Resident #74

right to dispute the citation through the informal dispute resolution process.

The facility will continue to ensure that each resident receives adequate supervision and transfer assistance as determined by the plan of care.

Resident #74 is receiving supervision and transfer assistance as determined by the plan of care. The fracture is healed and resident #74 had no lasting negative outcome as a result of being lowered to the floor.

Current residents requiring assistance with transfers have the potential to be affected. All care plans were audited between 12/15/14 and 12/19/14 to ensure that current residents are receiving transfer assistance according to plan of care. Care plans are reviewed periodically to ensure adequate supervision and assistance devices are in place.

Nursing Assistants will be in-serviced by the DON/designee on the facility's procedure for identifying and providing supervision and assistance devices to prevent accidents based on individual care plans.

A QA monitoring tool will be utilized to ensure ongoing compliance by the Unit Manager/designee. The Unit Manager/designee will randomly observe 3 resident transfers daily x 2 weeks then 3 times a week x 2 weeks then weekly x 1

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F 323	Continued From page 9 to her wheelchair. The nurse assessed Resident #74 and noted she moved all extremities well and denied pain. In a subsequent nurse's note on 08/02/14 at 11:30 AM the same nurse documented Resident #74 was grimacing and holding her right knee. The Physician was contacted and ordered a mobile x-ray of her right knee which noted a fracture and Resident #74 was sent to the hospital for further evaluation. Review of an incident report dated 08/02/14 stated Resident #74 was lowered to the floor while being transferred by a student NA. The nurse documented no injuries were noted at the time of the initial assessment. Review of a hospital emergency department report dated 08/02/14 revealed Resident #74 had a computed tomography (CT) scan and x-ray of the right knee and was diagnosed with a minimally displaced incomplete fracture of the medial tibial plateau. Resident #74 returned to the facility the same day with a brace on her right knee. Review of Student NA #1's written statement received by the facility on 08/05/14 revealed she assisted NA #1 with transferring Resident #74 to the toilet on 08/02/14. Student NA #1 stated when Resident #74 turned on the bathroom call light for further assistance she could not find an NA to assist her. Student NA #1 then tried to assist Resident #74 off the toilet without the supervision of her instructor or NA #1. Student NA #1 documented that Resident #74's right foot got twisted under her left and Student NA #1 realized she would not be able to get her to the wheel chair. Student NA #1 noted she turned on the emergency light and held Resident #74 for 1	F 323	month to ensure staff are performing transfers according to resident care plans. 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. 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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and 1/2 minutes until her arms became weak at which time she lowered her to the floor and went to get help.

Review of the facility's investigation dated 08/06/14 revealed Student NA #1 was assigned to work with NA #2 on 08/02/14. When Resident #74 needed assistance with transfer to the toilet Student NA #1 offered to assist NA #1 with the transfer. NA #1 and student NA #1 left Resident #74 to use the bathroom as she was able to ring for assistance when she was ready to get off the toilet. NA #1 responded to a call light across the hall and when she came out of the room NA #1 heard Resident #74 yelling and went into the bathroom immediately. NA #1 observed Student NA #1 squatting down behind Resident #74 holding her underneath her arms approximately 3 inches off the bathroom floor. Student NA #1 told NA #1 she had been a NA for several years and thought she could transfer Resident #74 safely from the toilet to her wheel chair without supervision from her instructor or NA #1.

An interview was conducted with the Director of Nursing (DON) on 12/11/14 at 9:38 AM. The DON stated she was notified of the incident involving Resident #74 on 08/02/14 and initiated an investigation into the incident on 08/04/14 which included interviews with staff and review of student NAs statements. The DON further stated student NAs were not allowed to transfer residents without supervision from their instructor or an NA.

An interview with NA #2 on 12/11/14 at 10:42 AM revealed Student NA #1 was assigned to work with him on 08/02/14. NA #2 stated he did not witness and was not involved with Resident #74's

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accident on 08/02/14. The interview further revealed Resident #74 was not an easy transfer and required 2 person assistance with transfers at the time of the incident.

An interview was conducted with NA #1 on 12/11/14 at 11:42 AM. During the interview NA #1 stated Student NA #1 was assigned to NA #2 on 08/02/14 but offered to assist her with transferring Resident #74 from her wheelchair to the toilet. NA #1 noted Resident #74 was a 2 person extensive assistance with transfer. NA #1 explained they left Resident #74 on the toilet as she was able to call for assistance when she was done using the toilet. NA #1 stated she went to assist another resident and when she came out of the room she heard yelling from Resident #74's bathroom and went straight to the room. NA #1 recalled Student NA #1 was squatting down behind Resident #74 holding her underneath her arms approximately 3 inches off the bathroom floor and one of her legs was under her. NA #1 stated she asked Student NA #1 her what happened and Student NA #1 told her she had lowered Resident #74 to the floor. NA #1 recalled Resident #74 was yelling and her first instinct was to get the weight off her leg so they assisted Resident #74 into her wheelchair and NA #1 went to notify the nurse.

An interview was conducted with the Assistant Director of Nursing (ADON) on 12/11/14 at 1:39 PM. The ADON stated she set up appointments and met with the NA program instructors prior to the student NAs first assigned day. The ADON noted she toured the facility with the instructor, gave suggestions for pairing student NAs with facility NAs and reviewed information including infection control, abuse, emergency responses,

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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
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and transfers. The ADON further stated she informed the instructors the student NAs were not allowed to transfer a resident without the supervision of the instructor or facility staff. The interview further revealed the ADON met with the student NAs on their first day in the facility to review information and had always instructed the students they were not allowed to transfer residents without supervision from their instructor or a staff member.

During a phone interview on 12/11/14 at 3:14 PM Student NA #1 confirmed she was assigned to work with NA #2 on 08/02/14. Student NA #1 stated when NA #2 went for a break he instructed her to assist NA #1. Student NA #1 could not recall if she assisted NA #1 with transferring Resident #74 from her wheelchair to the toilet. Student NA #1 stated they both left Resident #74 unsupervised in the bathroom. Student NA #1 explained she answered Resident #74's bathroom call light and went to find someone to assist her with transferring the resident from the toilet to her wheelchair but she could not find anyone. Student NA #1 stated she probably should not have transferred Resident #74 by herself because it was a bad mistake on her part. Student NA #1 stated she lowered Resident #74 to the floor and referred to her written statement because she could not recall any further details. The interview further revealed Student NA #1 also did not recall if she received specific instructions regarding transfers from the NA program instructor but did say they were told they needed to be supervised by an NA unless it was a simple task. Student NA #1 stated she did not consider transferring a resident a simple task.