STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	R-C 06/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SUMMIT RIDGE	100 RICEVILLE ROAD ASHEVILLE, NC 28805

(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 On June 19, 2019, The Division of Health Service Regulation, Nursing Home Licensure and Certification conducted a revisit. The facility remains out of compliance.	F 000		
{F 641} SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) functional status needs for 1 of 8 residents whose MDS assessments were reviewed (Resident #6). Findings included: Resident #6 was admitted to the facility on 01/19/15 with diagnoses which included hypertension and neuromuscular dysfunction of the bladder. The quarterly Minimum Data Set (MDS) dated 06/03/19 assessed Resident #6 as moderately impaired cognition with daily decision making and needed extensive assistance for most activities of daily living (ADL). Section G assessed his bathing as did not occur during the look back period. A further review of the MDS indicated Resident #6 had not refused any care during the look back period. A review of the nursing notes for Resident #6 from 05/28/19 through 06/03/19 revealed there	{F 641}	The Laurels of Summit Ridge wishes to have this submitted plan of correction stand as its written allegation plan of compliance. Our Compliance date is June 24, 2019. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope of severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. F641 Accuracy of Assessments Corrective Action: MDS Coordinator has corrected identified errors for Resident #6 on 06/20/2019. Corrective Action for those having the potential to be affected: All residents have the potential to be affected by the alleged deficient practice. All MDS with an ARD of 5/20/2019 thru	6/24/19

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

Electronically Signed | 07/02/2019

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{F 641}	Continued From page 1 were no nursing notes indicating the resident had refused his showers. An interview on 06/19/19 at 3:15 PM with MDS Nurse #1 revealed she got her information for bathing from the Nursing Assistants (NAs) documentation in Point of Care which is their documentation system. She stated Resident #6 was scheduled for showers on Mondays and Thursdays and his information for 06/03/19 indicated the resident refused his shower and she stated on 05/28/19 there was no documentation about his shower. MDS Nurse #1 stated she had no documentation stating she had asked the NAs, or the nurses assigned to the resident about his showers. MDS Nurse #1 stated she had not interviewed the resident about his showers and whether he had them or refused both for the week. An interview on 06/19/19 at 3:30 PM with NA #2 revealed he had given Resident #6 his showers and shaved him. NA #2 stated Resident #6 had not refused his showers. NA #2 stated most weeks Resident #6 had more than 2 showers per week because he had to be shaved often due to hair growth on his face. NA #2 stated he had not documented the showers he had given Resident #6 like he should have but stated he had given the resident his showers. An interview on 06/19/19 at 4:16 PM with Resident #6 revealed he received at least 2 showers per week and stated he had never refused his shower. Resident #6 stated he enjoyed his showers and looked forward to getting them weekly and getting shaved. Another interview on 06/19/19 at 4:24 PM with NA	{F 641}	06/20/2019 were audited by the MDS Coordinator for any coding of not rated or did not occur for section G any discrepancies were corrected with supporting documentation. No negative outcome noted due to this alleged deficient practice. Systematic Changes: Regional Clinical Resource Specialist will educate MDS staff on proper coding of section G of the MDS and the interview process by 06/24/2019. Monitoring: Director of Nursing or designee will audit sections G of completed assessments for accuracy weekly x 4 weeks, then every 2 weeks x 1 month, then monthly x 2 months to ensure MDS coding is accurate for section G. Audits to begin 6/24/2019. Results of the audits will be brought to QA by the Director of Nursing and reviewed monthly at the Quality Assurance Meeting for any further recommendations. The Administrator will be responsible for ensuring any further recommendations are carried out. Completion Date: 06/24/2019	

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{F 641}	Continued From page 2 #2 revealed no one had asked him about his lack of documentation of Resident #6's showers. NA #2 stated the nurses and the MDS nurses had not asked him about the documentation. An interview on 06/19/19 with the Director of Nursing (DON) revealed it was her expectation the MDS Nurses check their work for accuracy prior to completing the resident's MDS. The DON stated she would have expected the MDS Nurses to interview the resident, nurses and NAs responsible for Resident #6's care prior to marking the resident on the MDS as not having a bath for a week.	{F 641}		
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	{F 880}		6/24/19

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{F 880}	Continued From page 3 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	{F 880}		

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{F 880}	Continued From page 4 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to maintain infection control procedures for 1 of 1 resident (Resident #8) on contact precautions. The nurse was observed coming out of Resident #8's room with a gown on, wearing gloves and carrying open biohazard bags containing items from the resident's room. Findings included: Resident #8 was readmitted to the facility on 06/08/19 with metabolic encephalopathy and Shingles. A review of his quarterly Minimum Data Set (MDS) dated 06/08/19 revealed he was severely impaired for daily decision making and required extensive assistance of 1 to 2 staff with all activities of daily living (ADL). Resident #6 was on contact precautions for Shingles. An observation on 06/19/19 at 4:00 PM revealed there was a cabinet outside the door with a sign reading "Contact Precautions" laying on top of the cabinet and there were gowns, gloves and other supplies in the three drawers. The front of the sign read: Everyone Must: Clean hands when entering and leaving room Follow Standard Precautions	{F 880}	F880 Infection Prevention and Control Corrective Action: Nurse #1 was educated that gowns and gloves are never worn in the hallway as well as proper procedure for disposing of biohazard waste materials, soiled lien and or trash from a resident room. Corrective Action for those having the potential to be affected: All residents on isolation precautions have the potential to be affected by this alleged delinquent practice. Resident #8 was not affected by this alleged delinquent practice. Systematic Changes: Staff Development Coordinator and or Designee will in-service all staff on proper procedure for disposing of biohazard waste materials, soiled lien and or trash from a resident room and appropriate use of Personal Protective Equipment by 06/21/2019. Monitoring: Currently no residents are on isolation. If during the audit period a resident is placed on isolation the Infection Control Nurse or Designee will audit isolation protocol on any resident in isolation 3 x week x 4 weeks then 1 x week x 1 month then monthly x 2 months. Infection Control Nurse or designee will complete 5 competency questioning audits of random staff members 1 x week x 4 weeks, then	

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{F 880}	Continued From page 5 Gown and gloves when entering room Doctors and Staff Must: Use patient dedicated or disposable equipment. Clean and disinfect shared equipment. The back of the sign read: Personal Protective Equipment: Put ON in this order: 1. Wash or sanitize hands 2. Gown 3. Mask (if needed) 4. Eye Cover (if needed) 5. Gloves Take OFF and dispose in this order: 1. Gloves 2. Eye Cover (if used) 3. Gown 4. Mask (if used) 5. Wash or sanitize hands (even if gloves used) An observation on 06/19/19 at 4:30 PM revealed Nurse #1 coming out of Resident #8's room with a gown on and gloves on both hands holding open biohazard bags that contained biohazard materials from Resident #8's room. The nurse stated as she was walking down the hallway that she had on a clean gown and was just removing waste from the resident's room. An interview on 06/19/19 at 4:50 PM with Nurse #1 revealed she had put a clean gown on, so she would not have the biohazard waste next to her uniform. She stated the resident was on contact precautions for Shingles and she was not going	{F 880}	every 2 weeks x 1 month, then monthly x 2 months to determine if staff respond appropriately to infection control practices related to Personal Protective Equipment use and disposal of biohazard waste, soiled liens and or trash. Audits to begin 06/24/2019. Results of the audits will be brought to QA by the Director of Nursing and reviewed monthly at the Quality Assurance Meeting for any further recommendations. The Administrator will be responsible for ensuring any further recommendations are carried out. Completion Date: 06/24/2019	

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{F 880}	Continued From page 6	{F 880}		

to walk down the hall holding biohazard bags touching her clothing, so she put a clean gown on. She stated she had gloves on both hands because she was carrying biohazard bags in both hands and did not want to touch them with her bare hand. She stated she had opened the dirty utility room door with her gloved hand that had held the biohazard bag that was open but had not cleaned the door knob. Nurse #1 stated she always wore 2 gloves out in the hallway when carrying dirty items to the dirty utility room. Nurse #1 could not recall what she had been instructed to do at the nursing home and could not remember if and when she had had education on contact precautions.

An interview on 06/19/19 with the Infection Control Nurse revealed the nurses and nursing assistants received infection control education upon hire, as needed and annually. The Infection Control Nurse stated Nurse #1 should not have worn a gown out into the hallway, should not have worn gloves on both hands and should not have had open biohazard bags in the hallway. The Infection Control Nurse stated Nurse #1 had not followed proper procedure for contact precautions.

An interview on 06/19/19 at 6:15 PM with the Director of Nursing (DON) revealed she expected the Nurses and NAs to follow proper procedures when disposing of biohazard bags from Resident #8's room containing biohazard materials. The DON also stated Nurse #1 should never wear a gown out in the hallway, gloves on both hands and have open biohazard bags out in the hallway.

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation of 06/19/19. Event ID# T9KE11.	F 000		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to handle dirty water cups in a sanitary manner when a nursing assistant (NA) was observed dropping two water cups on the floor, filling the same cups with ice and serving them to 2 of 2 sampled residents (Resident #1 and Resident #3). The findings included:	F 812	The Laurels of Summit Ridge wishes to have this submitted plan of correction stand as its written allegation plan of compliance. Our Compliance date is June 24, 2019. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope of severity of the cited deficiencies. This plan is prepared and/or executed to	6/24/19

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

Electronically Signed | 07/02/2019

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F 812	Continued From page 1 Resident #1 was admitted into the facility on 03/25/19. Review of the most recent comprehensive Minimum Data Set (MDS) dated 04/01/19 revealed Resident #1 was cognitively intact for daily decision making. On 06/19/19 at 10:56 AM Nurse Assistant (NA) #1 was observed passing ice to the residents. NA #1 was observed dropping Resident #1's cup on the floor. She picked the cup up off of the resident's floor, filled it with ice and water then placed it on Resident #1's table in front of him. NA #1 was then observed dropping Resident #3's cup on the floor. She picked the cup up off of the resident's floor, filled it with ice then placed it on Resident #3's table and poured his cola into the cup. NA #1 proceeded to exit the resident's rooms until stopped by the surveyor, asked to provide the residents with clean cups and to remove the dirty cups from the resident's tables. On 06/19/19 at 11:00 AM an interview was conducted with NA #1. She stated she had dropped Resident #1 and Resident #3's water cups onto the floor, picked them up, placed ice in them and served them to the residents. The interview revealed she should have removed the dirty cups after dropping them onto the floor and provided the residents clean cups from the kitchen. She stated clean cups were located in the dining room and available for staff to access at all times. On 06/19/19 at 3:06 PM an interview was conducted with the Director of Nursing (DON). She stated she expected NA #1 to maintain sanitary conditions by providing the residents with clean cups after dropping their cups onto the floor. The interview revealed clean cups were	F 812	ensure compliance with regulatory requirements. F812 Food Procurement Store/Prepare/Serve-Sanitary Corrective Action: Nurse Aide #1 removed water pitcher from Resident #1 and Resident #3 room and replaced it with a clean water pitcher from the dietary department. Corrective Action for those having the potential to be affected: All residents have the potential to be affected by this alleged delinquent practice. All resident water pitchers were removed from their rooms and replaced with clean sanitized water pitchers by central supply clerk. Systemic Changes: Staff Development Coordinator and or designee will in-service all staff on proper sanitation procedures when passing ice to residents by 06/24/2019. Monitoring: Unit Managers and or designee will observe ice passing on each unit 1 x day at the 10am or 2pm ice pass 2 x week x 4 weeks then monthly x 2 months to ensure proper sanitation procedures are being followed during ice pass to residents. Audits to begin 06/24/2019. Results of the audits will be brought to QA by the Director of Nursing and reviewed monthly at the Quality Assurance Meeting for any further recommendations. The Administrator will be responsible for ensuring any further recommendations	

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F 812	Continued From page 2 available at all times in the kitchen. On 06/19/19 at 4:05 PM an interview was conducted with Resident #1. During the interview he stated he was upset over seeing NA #1 dropping the cups onto the floor and not immediately providing him with a clean cup. He stated this incident had occurred before and was unacceptable.	F 812	are carried out. Completion Date: 06/24/2019	