PRINTED: 02/27/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SUR\ COMPLETE	
		345303	B. WING _			R-C 02/02/2	2017
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL)E		-
				70 SWEETEN CREEK ROAD			
THE LAUR	ELS OF GREENTREE R	IDGE		ASHEVILLE, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) MPLETION DATE
SS=D	must be provided by	E PLAN I or arranged by the facility	{F 2	82}		2/23	3/17
	by: Based on observation interviews, the facility of a gastrostomy feed administering water for receiving medications #159). The findings in Resident #159 was at 09/10/15 with multiple dysphasia (difficulty severely impaired. The #159 required extensistaff for all activities of over 51% of nutrition through the abdomen directly to the stomace. A care plan dated 12 #159 at risk for aspirar related to a diagnosis. The care plan goal spibe free of signs and sedifficulty through the rincluded administer to ordered and check tules.	or 1 of 3 residents observed alwater via g tube (Resident included: dmitted to the facility diagnoses which included wallowing). Data Set (MDS) dated resident's cognition was ne MDS specified Resident ive to total dependence on f daily living and received via GT (a tube inserted that delivers nutrition		The facility will continue to p arrange services by qualified accordance with each resider plan of care. Resident #159 continues to h placement of the gastrostomy checked by the DON in according the resident's plan of care. No outcome was identified relating observation. Current residents with gastrostomy the residents with gastrostomy the reviewed by the DON to ensure placement of the gastrostomy being checked by qualified perfective accordance with each resident care. No negative observation identified. Nurse #1 was inserviced by A facility's policy for checking put the gastrostomy tube in accordance each resident's plan of care. All licensed nurses will be instantional accordance with facility's policy.	persons in nt's written have y tube rdance with lo negative ng to this lestomy tube sted. Curre lubes were ure that y tube is ersons in nt's plan of ons were had accement of the lacement of	h es es ent f	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

02/21/2017

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		PLETED
		345303	B. WING				-C 02/2017
	ROVIDER OR SUPPLIER			70	IREET ADDRESS, CITY, STATE, ZIP CODE SWEETEN CREEK ROAD SHEVILLE, NC 28803	<u> 021</u>	02/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 282}	Nurse #1 began by ac water into the GT. W should have been che water flush followed bestopped the procedur and checked tube pla In an interview on 02/explained she always GT before administer stated she forgot to dadded she should hav because that was fac. An interview with the	AM, Nurse #1 was and g tube to Resident #159. Idministering 30 milliliters of then asked if GT placement ecked before administering by medications, Nurse #1 to obtained a stethoscope cement via auscultation. 102/17 at 12:08 PM Nurse #1 to checked placement of the ing any fluids. Nurse #1 to that today. Nurse #1 to checked placement	{F 2	282}	placement of the gastrostomy tube in accordance with each resident's plan of care. A QA monitoring tool will be utilized to ensure ongoing compliance by the ADO Nurse #1 will be observed weekly x 4 weeks to ensure that placement of the gastrostomy tube is being checked in accordance with each resident's plan of care. All other licensed nurses will be observed x 1 to ensure that placement the gastrostomy tube is being checked accordance with each resident's plan of care. The ADON will randomly observed x weeks then randomly x 2 months to ensure that placement of the gastrostomy tube is being checked in accordance weach resident's plan of care. Variances will be corrected at the time of the observation and additional education provided when indicated. Observation results will be reported to the DON weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitore through random medication pass observations by the DON/ADON and through the facility's Quality Assurance Program. Compliance will be monitored by the Q Committee for 3 months or until resolve and additional education/training will be and additional education/training will be	on. f of in f e all ly x my ith s d	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345303	B. WING			l	-C 02/2017
	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE SWEETEN CREEK ROAD SHEVILLE, NC 28803	<u> 02/</u>	02/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 282}	Continued From page	2	{F 2	82}	provided for any issues identified.		
{F 322} SS=D	483.25(g)(2) NG TRE RESTORE EATING S	ATMENT/SERVICES - SKILLS	{F 3	22}	,		2/23/17
	Based on the compre resident, the facility m	hensive assessment of a nust ensure that					
	alone or with assistantube unless the reside	s been able to eat enough ace is not fed by naso gastric ent's clinical condition e of a naso gastric tube was					
	gastrostomy tube reco treatment and service pneumonia, diarrhea, metabolic abnormaliti	fed by a naso-gastric or eives the appropriate es to prevent aspiration vomiting, dehydration, es, and nasal-pharyngeal if possible, normal eating					
	TI: DEGUIDEMENT						
	by: Based on observation interviews, the facility of a gastrostomy feed administering medication 1 of 3 residents ob medications/water via findings included: Resident #159 was administration of the facility of the facilit	tions and nutritional feeding oserved receiving a GT (Resident #159). The			The facility will continue to ensure that resident who is fed by a naso-gastric or gastrostomy tube receives the appropri treatment and services to prevent aspiration pneumonia, diarrhea, vomitir dehydration, metabolic abnormalities, a nasal-pharyngeal ulcers and to restore possible, normal eating skills. Resident #159 continues to have	r iate ng, and	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION S	` ′	ATE SURVEY DMPLETED
		345303	B. WING			R-C 02/02/2017
NAME OF P	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP CODE		02/02/2017
TWANTE OF T	TOVIDER OR OUT FIER					
THE LAUF	RELS OF GREENTREE R	RIDGE		70 SWEETEN CREEK ROAD		
				ASHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 322}	Continued From page	e 3	{F 32	2}		
	dysphasia (difficulty s	swallowing).		placement of the gastrostomy tub	е	
		3,		checked per facility protocol. No		
	A quarterly Minimum	Data Set (MDS) dated		outcome was identified relating to	-	
		e resident's cognition was		observation.		
		he MDS specified Resident				
		ive assistance to total		Current residents that have naso-	gastric	
		for all activities of daily living		or gastrostomy tubes have the po		
	and received over 51	% of nutrition via GT (a tube		be affected. Current residents the	at have	
	inserted through the	abdomen that delivers		naso-gastric or gastrostomy tubes	s were	
	nutrition directly to the	e stomach).		reviewed by DON to ensure that		
				placement of the gastrostomy tub	e is	
	A care plan dated 12	/05/16 identified Resident		being checked per facility protoco		
	#159 at risk for aspira	ation and respiratory difficulty		negative observations were identi	fied.	
	related to a diagnosis	s of dysphagia requiring a				
	GT. The care plan go	oal specified the resident		Nurse #1 was inserviced by the A	DON on	
	would be free of signs	s and symptoms of		the facility's protocol for checking		
	respiratory difficulty.	Interventions included		placement of the gastrostomy tub	es.	
	administer tube feedi	ng and flushes as ordered				
	and check tube place	ement and residuals prior to		All nurses will be inserviced by the	e ADON	
	administering tube fe	edings and flushes.		on the facility's protocol for check	ing	
				placement of gastrostomy tubes.		
	On 02/02/17 at 11:56	AM, Nurse #1 was				
	observed administeri	ng medications and		A QA monitoring tool will be utilize	ed to	
		g tube to Resident #159.		ensure ongoing compliance by the	e ADON.	
	Nurse #1 began by a	dministering 30 milliliters of		Nurse #1 will be observed weekly		
	water into the GT. W	/hen asked if GT placement		weeks to ensure that placement of	of the	
	should have been ch	ecked before administering		gastrostomy tube is being checke		
	the water flush follow	ed by medications, Nurse #1		the facility protocol. All other lices	nsed	
	stopped the procedur	re obtained a stethoscope		nurses will be observed x 1 to ens	sure that	
	and checked tube pla	acement via auscultation.		placement of the gastrostomy tub	e is	
	The GT was determing	ned to be properly placed.		being checked per the facility pro-	tocol.	
		o administer medications,		The ADON will randomly observe		
	· · · · · · · · · · · · · · · · · · ·	itritional feeding following		residents with gastrostomy tubes	•	
		hysician's orders. The		4 weeks then randomly x 2 month		
	resident demonstrate	d no signs and symptoms of		ensure that placement of the gast	-	
		procedure was completed.		is being checked per the facility p		
		/02/17 at 12:08 PM Nurse #1		Variances will be corrected at the	time of	
		s checked placement of the		the review and the additional edu	cation	
	GT before administer	ing any fluids. Nurse #1		provided when indicated.		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345303	B. WING				-C (02/2017
	ROVIDER OR SUPPLIER			S1 70	TREET ADDRESS, CITY, STATE, ZIP CODE SWEETEN CREEK ROAD SHEVILLE, NC 28803	<u> 02/</u>	02/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520 SS=D	added she should have because that was factor of the course of the	o that today. Nurse #1 we checked placement ility protocol. Director of Nursing (DON) M revealed it was a or placement to be checked medications/fluids through it was the protocol of this andard of practice. ERS/MEET in a quality assessment and consisting of the director of hysician designated by the other members of the ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of iffied quality deficiencies. eary may not require rds of such committee h disclosure is related to the	{F 3	522}	Review results will be reported to the DON weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitore through random medication pass observations by DON/ADON and through facility's Quality Assurance Program Compliance will be monitored by the QCommittee for 3 months or until resolve and additional education/training will be provided for any issues identified.	d gh n. A	2/23/17

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345303	B. WING		R-C 02/02/2017
	ROVIDER OR SUPPLIER	RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803	02/02/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 520	and correct quality de a basis for sanctions. This REQUIREMENT by: Based on observation interviews, the facility Assurance Committee implement intervention into compliance for 2 recertification survey during this follow up a repeated deficiencies following the care plathe care of a gastrost repeated deficiencies of record show an isolinability to implement Assurance Program. The findings included This tag is crossed read staff interviews, the sanctions of the care of a gastrost repeated deficiencies of record show an isolinability to implement Assurance Program.	by the committee to identify efficiencies will not be used as a sericiencies will not be used as a sericiencied and and procedures and and procedures to come deficiencies cited during the of 12/09/16 and recited survey of 02/02/17. The as were in the areas of an and providing services for and providing services for any feeding tube. These as during two federal surveys plated pattern of the facility's an effective Quality.	F 52	The facility will continue to ensure the the quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develop and implements appropriate plans of action to correct identified quality deficiencies. Resident #159 continues to have placement of the gastrostomy tube checked by qualified persons in accordance with facility protocol and resident's plan of care. No negative outcome was identified relating to this observation. Current residents with gastrostomy to have the potential to be affected. Physician orders and care plans of all	s the s ubes
	gastrostomy feeding administering water f receiving medications #159). The facility was origin recertification survey	or 1 of 3 residents observed s/water via g tube (Resident		residents with gastrostomy tubes wer audited by DON to ensure that place of gastrostomy tubes was being chec Physician orders and care plans are reviewed periodically by DON/ADON Manager to ensure that placement of gastrostomy tubes is being checked in qualified persons in accordance with facility protocol.	ment ked. /Unit the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
				_		I	-C
		345303	B. WING			02/	02/2017
	ROVIDER OR SUPPLIER RELS OF GREENTREE R	IDGE		70	TREET ADDRESS, CITY, STATE, ZIP CODE SWEETEN CREEK ROAD SHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	sit to stand transfers a number of side rails properties of the plan of correction interventions specific needed for lift transferals to be used and rathe GT as that was not practice during the real staff interviews, the plan of a gastrobefore administering feeding for 1 of 3 resimedications/water via the facility was origin recertification survey clarify physician orde flushes to be given be administration and for amount of flushes properties of the plan of correction for gastrostomy tubes documented on the Mecord and not on che GT prior to administration.	and failure to use the per the care plan. In 02/02/17 at 3:44 PM, the he facility had concentrated on following the care plan to the number of people and the number of side not on checking placement of the properties and the number of side not on checking placement of the an identified deficient certification survey. In the facility failed to check the facility failed to check the stomy feeding tube (GT) medications and nutritional dents observed receiving a GT (Resident #159). In the facility failed to the amount of the facility failed during a con 12/09/16 for failure to the series and after medication and after medication and failure to document the povided. In 02/02/17 at 3:44 PM, the she facility had concentrated on ensuring the flush orders are were clear, followed and fedication Administration the placement of the lation of formula or fluids as fied deficient practice during	F	520	The facility's quality assurance commit will be inserviced by the Regional QA Manager on the procedures for developing and implementing appropria plans of action to correct identified qual concerns. Education will include determining the root cause of the identified concern, identifying, implementing, and monitoring the corrective action plan and recognizing when an action plan may need to be revised. A QA monitoring tool will be utilized to ensure compliance by the Regional QA Manager/designee. The Regional QA Manager/Regional Operator will attend facility quality assurance meeting mont x 2 months to ensure committee is developing and implementing appropria plans of action to correct quality concervariances will be corrected and/or additional education provided when indicated. The Regional Quality Assurance Nurse/Regional Operator will review th facility's quality assurance action plans monthly for the next 3 months then randomly thereafter to ensure continue compliance.	the hly ate rns.	