STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345303	A. BUILDING: _____ B. WING _____	7/1/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 253	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES

(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interviews, the facility failed to thoroughly clean a personal shower chair after use for 1 of 3 residents observed for physical environment (Resident #1).

The findings included:

Resident #1 was admitted to the facility 09/10/17 with diagnoses which included traumatic brain injury.

A quarterly Minimum Data Set (MDS) dated 05/02/17 indicated Resident #1's cognition was severely impaired. The MDS specified the resident was nonverbal and required extensive to total staff assistance for all activities of daily living including bathing.

An observation on 06/29/17 at 11:53 AM revealed a shower chair stored in Resident #1's private bathroom. The chair was dry and the bottom cross bar between the 2 front wheels of the shower chair was observed with 3 streaks approximately 1/4 to 1/8 of an inch wide of a dark colored substance in the middle of the bar.

An additional observation on 06/30/17 at 9:15 AM revealed the dark colored streaks were still visible on the shower chair. The chair was dry and continued to be in same position as observed on 06/29/17 and was stored in the resident's private bathroom.

At 9:45 AM on 06/30/17, Resident #1 was observed lying the bed with wet hair. Nurse Aide (NA) #3 was with the resident and stated she had just given Resident #1 a shower, used the resident's shower chair, and had gotten assistance from another NA to put the resident back to bed to be dressed. NA #3 stated she was aware the shower chair needed to be cleaned which she would do after drying the resident's hair. When asked, NA #3 added she was unaware the cross bar at the bottom of the shower chair was soiled before providing the shower for the resident but was aware the cross bar was soiled during this shower.

An interview and observation was conducted with the Director of Nursing (DON) on 06/30/17 at 9:58 AM. The DON observed the dark colored streaks were on the bottom cross bar on the shower chair in Resident #1's bathroom and the shower chair was wet. She confirmed the cross bar was unclean with a dark colored substance. The DON stated the shower chair should always be cleaned per facility protocol following by staff providing the shower after each use.

The above isolated deficiencies pose no actual harm to the residents

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 07/01/2017

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 166 SS=C	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		7/29/17

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

Electronically Signed | 07/21/2017

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 07/01/2017

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 166	Continued From page 1	F 166		

conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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 07/01/2017

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 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility ' s grievance policy failed to contain the residents' rights: to notify resident individually or through postings in prominent locations throughout the facility of the right to file grievances, the information a written grievance decision should contain, the contact information of independent entities with whom grievances may be filed such as pertinent State agency, State Long Term Care Ombudsman program or Quality Improvement Organization, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated and take appropriate corrective action in accordance with State law if the alleged violation the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility. The policy further failed to provide information of the facility ' s grievance official by stating name, business address (mailing and email), and business phone number and a statement that evidence demonstrating the results of all grievances will be maintained for a period of 3 years.	F 166	The facility will continue to ensure that the grievance policy allows for the prompt resolution of al grievances regarding applicable resident rights. Current residents have the potential to be affected. The grievance policy was revised to include all required items. All current residents were given a copy of the revised grievance policy. No negative outcomes were identified relating to this observation. All new residents will be notified of the grievance process through the admission intake. All staff will be in-serviced by the Administrator on the facility's revised grievance policy. A QA monitoring tool will be utilized to ensure ongoing compliance by the Social Worker. The Social Worker will conduct random resident interviews weekly x 4 weeks then randomly x 2 months to ensure that residents are aware of the facility's revised grievance policy. Variances will be corrected at the time of	

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 07/01/2017

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 166	Continued From page 3 The findings included: A review of an undated grievance policy provided by the facility specified in part the facility had a grievance process that allowed easy reporting of complaints to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. The policy further explained subjects that could be grieved. The policy also contained grievances will be thoroughly investigated and corrective actions will be applied in a timely manner. During an interview on 07/01/17 at 9:20 AM the Administrator stated this policy was from corporate policies dated December 2016. She provided information regarding filing of a grievance residents and families received during the admission process. This information advised of the right to grieve issues and the procedure to be followed. The Administrator state written statements have been provided to families or residents that filed a grievance and provided written statements that had been issued. The Administrator acknowledged the facility's grievance policy did not include all the items that were required in current grievance policies.	F 166	interview and additional education provided when indicated. Interview results will be reported to the Quality Assurance Committee monthly for the next 3 months. 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. Administrator will be responsible for implementing the acceptable plan of correction.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (1) A system for preventing, identifying, reporting,	F 441		7/29/17

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 07/01/2017

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 441	Continued From page 4	F 441		

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 accepted national standards (facility assessment implementation is Phase 2);

(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

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 07/01/2017

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 441	Continued From page 5 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 observations, record review, and staff interviews the facility failed to change gloves and wash hands following immediate incontinence care and removal of a soiled brief for 1 of 3 residents reviewed for implementation of infection control procedures (Resident #4). The findings included: A review of the facility's undated policy for glove use revealed in part gloves should be replaced as soon as possible when contaminated. Gloves should be used when touching body fluids and handling potentially contaminated items. Resident #4 was admitted to the facility 06/12/17 with diagnoses which included diarrhea with Clostridium difficile (C-diff, a bacteria passed in feces. The bacteria produces spores that can persist in a room for weeks.) An admission	F 441	The facility will continue to ensure that standard and transmission-based precautions are followed to prevent the spread of infections. Resident #4 no longer resides at the facility. No negative outcome was identified relating to this observation. Nurse Aide #1 and Nurse Aide #2 were in-serviced by the ADON on the facility policy/expectations for Contact Precautions. Current residents that require contact isolation have the potential to be affected. Current residents that require contact isolation were observed to ensure that staff were utilizing standard and transmission-based precautions to prevent the spread of infections. No	

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 07/01/2017

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 441	Continued From page 6 Minimum Data Set (MDS) dated 06/19/17 described Resident #4 with intact cognition and required extensive staff assistance for transfers and toileting. The MDS specified the resident was always incontinent of bowel. A Care Area Assessment specified Resident #4 was admitted to the facility following a hospital admission where the resident was diagnosed with C-diff. The resident continued on contact isolation with antibiotic treatment. A care plan dated 06/23/17 described Resident #4 with an alteration in bowel elimination related to C-diff and at risk for dehydration. Interventions included administer medications for C-diff as ordered, attempt to contain feces, use incontinent products as needed, and contact isolation as ordered. An observation on 06/29/17 at 10:35 AM revealed a contact precaution sign on the door to Resident #4's room. A cart containing disposable gowns, gloves, and large plastic bags was noted outside the room door. An observation of incontinence care was conducted on 06/30/17 at 10:04 AM with Nurse Aide (NA) #1 and NA #2 providing the care for Resident #4 while wearing disposable gowns and gloves. NA #2 placed 2 small plastic bags on the bottom sheet toward the foot of the resident ' s bed. The resident's brief was unfastened and the resident was rolled toward NA #1. NA #2 was observed cleaning a small amount of watery stool using bath cloths and soap and water. After each bath cloth was used, it was placed in one of the plastic bags at the foot of the bed. After cleaning away the stool and removing the soiled brief which was placed in the other plastic bag at the	F 441	negative outcome was identified relating to this observation. All nursing assistants will be in-serviced by the ADON on facility policy/expectations for Contact Precautions. A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON. The ADON will randomly observe all residents requiring Contact Precautions weekly x 4 weeks then randomly x 2 months to ensure that NA's are following the facility policy/expectations for Contact Precautions. Variances will be corrected at the time of observation and additional education provided when indicated. Observation results will be reported to the Quality Assurance Committee monthly for the next 3 months. 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. ADON will be responsible for implementing the acceptable plan of correction.	

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 07/01/2017

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 441	Continued From page 7	F 441		

foot of the bed, NA #2 continued care without changing gloves or washing his hands. NA #2 was observed tying the top of each plastic bag and dropping both bags on the floor next to the resident ' s bed. Using the same gloves, NA #2 was observed fastening the clean brief and positioning 4 pillows under the resident's legs and feet. When NA #2 started picking up the top covers, he was asked if he ever changed his gloves after removing stool from a resident's skin, the NA replied he should have changed the gloves and washed his hands before applying the clean brief. NA #2 was observed removing the soiled gloves and placing them in the small plastic lined trash can next to the resident's bathroom. NA #2 was observed washing his hands at the bathroom sink before donning clean gloves.

An interview was conducted with the facility's Medical Director (MD) on 06/30/17 at 10:35 AM. The MD stated Resident #4 was admitted to the facility with a diagnosis of C-diff. The MD explained this diagnosis does require contact isolation even though it was rarely carried from person to person. The MD further explained spores from this bacteria can linger in a room for days after the resident has been discharged and thorough cleaning was necessary.

An interview with the Assistant Director of Nursing (ADON) was conducted on 06/30/17 at 11:35 AM. The ADON stated NA #2 should have changed gloves and washed hands after the immediate incontinence care and before proceeding with redressing and positioning the resident.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0463	A. BUILDING: _____ B. WING _____	C 07/01/2017

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) COMPLETE DATE
L 000	INITIAL COMMENTS No deficiencies were cited as results of a complaint investigation. Event ID #T60S11.	L 000		

Division of Health Service Regulation

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

Electronically Signed | 07/11/17