

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/03/2018
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NAME OF PROVIDER OR SUPPLIER THE LAURELS OF GREENTREE RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803
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(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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F 580 SS=D	<p>Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p>	F 580		5/1/18
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/23/2018
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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.

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F 580	<p>Continued From page 1</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility failed to notify a resident's Responsible Party (RP) regarding the resident being sent to the hospital from a dialysis center due to an episode of low blood pressure for 1 of 3 residents reviewed for notification (Resident #1). The findings included: Resident #1 was admitted to the facility 07/07/17 with diagnoses which included end stage renal disease. The most current Minimum Data Set, a quarterly dated 12/26/17 indicated the resident's cognition was intact. A review of hospital records revealed an emergency room (ER) report signed by the ER physician specified Resident #1 arrived in the emergency room at 8:11 AM on 02/05/18. The ER report further specified the resident arrived via ambulance from a dialysis center. Continued review of hospital records revealed a history and physical (H&P) signed by a hospital physician and dated 02/05/18 described Resident #1 as alert, no complaints of pain, and a systolic blood pressure of 79 upon arrival to the ER. The H&P specified the resident experienced a syncopal</p>	F 580	<p>The facility failed to notify a resident's Responsible Party (RP) regarding the resident being sent to the hospital from a dialysis center due to an episode of low blood pressure.</p> <p>The facility will continue to ensure that the resident representative is informed when there is a decision to transfer or discharge the resident from the facility.</p> <p>Resident #1 no longer resides in the facility.</p> <p>Current residents that receive outpatient dialysis have the potential to be affected. The facility does not currently have any residents that receive outpatient dialysis services.</p> <p>Nurse #1 and Nurse #3 were inserviced by the DON on informing the resident representative when there is a decision to transfer or discharge the resident from the facility.</p> <p>A QA monitoring tool will be utilized to</p>		

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F 580	<p>Continued From page 2</p> <p>(fainting) episode after being on the dialysis machine less than 30 minutes and was transported to the ER via ambulance and was admitted to the hospital.</p> <p>An interview was conducted via phone on 04/03/18 at 11:26 AM with Resident #1's RP. He stated he was not informed of the resident being sent to the hospital on 02/05/18 until he went to the facility around 5:30 PM on that day. He explained he could not find the resident in her room and was told by a nurse she was transported to the hospital from the dialysis center.</p> <p>An interview was conducted via phone with Nurse #3 on 04/03/18 at 3:37 PM. Nurse #3 stated she was assigned to Resident #1's hall on 02/05/18. Nurse #3 stated when she arrived at the facility Resident #1 had already been transported to the dialysis center. She explained she received a phone call sometime that morning from dialysis center personnel who reported the resident had been sent to the hospital due to a low blood pressure. Nurse #3 further explained she did not notify the resident's RP because she assumed the dialysis center personnel did that. She stated notification of residents' families had been the dialysis center's usual practice in the past. The nurse was unable to recall if this dialysis center personnel reported to her on 02/05/18 that they had notified the RP of the resident's transport to the hospital. Nurse #3 added she did not see Resident #1's RP in the facility that day.</p> <p>An interview was conducted with Nurse #1 on 04/03/18 at 3:45 PM. Nurse #1 stated she worked in the facility on 02/05/18. She did recall Resident #1's RP coming to the facility around</p>	F 580	<p>ensure ongoing compliance by the DON weekly x 4 weeks then randomly x 2 months to ensure that resident representatives are informed when there is a decision to transfer or discharge the resident from the facility. Variances will be corrected at the time of the observation and additional education provided when indicated.</p> <p>Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings.</p> <p>Continued compliance will be monitored by the DON through random observations, acute charting reviews, and through the facility's Quality Assurance Program.</p> <p>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.</p> <p>The DON will be responsible for implementing this plan of correction.</p>		

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F 580	Continued From page 3 6:00 PM on that day. She explained the RP was asking about Resident #1 because the resident was not in her room. Nurse #1 informed the RP that Resident #1 had been sent to the hospital from the dialysis unit that morning. An interview was conducted with the Administrator of 04/03/18 at 4:16 PM. The Administrator stated she expected the dialysis center personnel to notify family members when a resident was sent to the hospital by dialysis center personnel.	F 580		