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 02/16/2021

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 The survey team entered the facility on 02/11/21 to conduct a complaint investigation and exited on 02/12/21. Additional information was obtained through 02/16/21. Therefore, the exit date was changed to 02/16/21. There was 1 allegation investigated and it was substantiated. Event ID #7IQG11.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, family, and physician interviews, the facility failed to provide care in a safe manner to prevent a fall from the bed which resulted in left forehead laceration that required a transfer to the hospital for staples for 1 of 3 sampled residents reviewed for supervision to prevent accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 09/12/08 with diagnoses which included anoxic brain damage, dementia, seizure, quadriplegia, and contracture of joints. Review of Resident #1's annual Minimum Data	F 689	The facility will continue to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistive devices to prevent accidents. Resident #1 received treatment in the emergency room on 1/30/21, no negative outcome was identified relating to this occurrence. All current resident beds with side rails were inspected by the maintenance director and concerns were identified 2/11/21. A root cause analysis was conducted on	3/12/21

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

Electronically Signed | 03/12/2021

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 02/16/2021

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 689	Continued From page 1 Set (MDS) dated 01/15/21 revealed assessments of severely impaired cognition, unclear speech, severely impaired vision, and always incontinent with bowel and bladder. Resident #1 was coded with bilateral impairments of lower and upper extremities and required total assistance of 2 persons with bed mobility, transfer, and toilet use. The MDS documented Resident #1 had no falls since the prior assessment. Review of Resident #1's care plan for falls dated 08/20/20 revealed interventions to prevent falls included keeping bilateral padded side rails in the up position while Resident #1 was in the bed and providing assistive devices as ordered. Review of care plan for Activities of Daily Living (ADL) dated 01/19/21 revealed Resident #1 required 1-2 persons assist with bed mobility, incontinence care, and toileting. Review of a nursing note dated 01/30/21 revealed Resident #1 was on the floor at the right side of the bed. He suffered injury by the fall during incontinence care provided by Nurse Aide (NA) #1. Resident #1 was sent to Emergency Room (ER) for treatment and evaluation and returned to the facility on the same day. Review of hospital discharge summary revealed Resident #1 sustained a laceration to the left scalp that required staples. Review of an incident report dated 01/30/21 by Nurse #1 revealed Resident #1 rolled off the bed when NA #1 was providing incontinence care. The side rail at the right side of the bed collapsed unexpectedly when NA #1 was turning and changing Resident #1. The bilateral full side rails were evaluated by the Director of Maintenance	F 689	1/31/21. Current residents requiring padding to side rails have the potential tp affected. All current resident beds with padding to side rails were inspected on 1/31/21 and no concerns were identified. NA #1 was in-serviced by the ADON on removing padding while providing care and replacing padding only after the side rail has been raised and locked in place on 1/31/21. All nursing assistants were in-serviced by the ADON on removing padding while providing care and replacing padding only after side rails has been raised and locked in place. This was completed on 2/1/21. All nursing assistants, licensed nurses, and therapists were in-serviced by the ADON on rolling residents toward the caregiver while providing care and was completed on 2/16/21. A QA monitoring tool will be utilized by the DON/designee to ensure ongoing compliance. The DON/designee will randomly observe NA's performing bed mobility for 2 residents requiring padding to the side rails 5x a week x 2 weeks then 3x a week for 2 weeks and then 1x monthly to ensure staff are removing padding while providing care and replacing padding only after side rails have been raised and locked in place. This began on 2/1/21.	

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 02/16/2021

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 689	Continued From page 2 next morning. No mechanical malfunctions were identified. A phone interview with NA #1 on 02/11/21 at 3:16 PM revealed she had provided care for Resident #1 frequently. When she rounded Resident #1 on 01/30/21 around 3:30 AM, she found Resident #1 was sweating heavily. She decided to change his gown and brief. She started at the right side of the bed by lowering the side rail down. Then she washed and turned Resident #1 while the side rail at the opposite side was in the up position. After finished cleaning at the right side of the bed, she pulled up the side rail. She stated she could feel the side rail locked into position as she had done many times in the past. Then, NA #1 went to the left side of the bed, lowered the side rail, and finished the rest of the cleaning. When she began to put on the new brief for Resident #1, NA #1 rolled Resident #1 away from her. Once Resident #1 was at the right side of the bed, the side rail at the right collapsed and he fell off from the bed. She went to the door quickly to holler for help. Nursing staff responded immediately. NA #1 denied she had rolled Resident #1 too far to the right of the bed before the fall. NA #1 added Resident #1 started to have seizure after the fall. A phone interview with Nurse #1 on 02/11/21 at 9:14 PM revealed she was the first staff who responded to NA #1's request for assistance on the morning of 01/30/21. When she entered the room, Resident #1 was lying on the floor at the right side of the bed and bleeding from the left forehead above the ear. The bilateral side rails were not in the up position. She directed NA #1 to summon additional help immediately. She applied pressure to the bleeding until Emergency Medical Service (EMS) arrived. Then she called Resident	F 689	A QA monitoring tool will be utilized by the DON/designee to ensure ongoing compliance. The DON/designee will randomly observe 3 NA's performing bed mobility daily x2 weeks then 3x a week x2weeks and then 1x a month to ensure staff are rolling the residents toward the caregiver while providing care. Variances will be corrected at the time of the observation and additional education provided when indicated. This began on 2/22/21. Observation results will be reported to the Administrator weekly for the next 2 months and concerns will be reported to QA committee during the monthly meetings 3/3/21. tentatively 3/24/21, and 4/21/21 tentatively. Continued compliance will be monitored through random observations of care and through the facility QA program. Compliance will be monitored by the QA community for 2 months or until resolved and additional education/ training will be provided for any issues identified.	

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 02/16/2021

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 689	Continued From page 3	F 689		

#1's Responsible Party (RP) to report the incident.

A phone interview with Nurse #3 on 02/12/21 at 3:10 PM revealed she was the hall nurse for Resident #1 on the morning of 01/30/21. She stated Resident #1 was a total dependent resident who required 1-2 staff for bed mobility. When she responded to NA #1's request for help, she saw Nurse #1 was holding Resident #1's head with a washcloth as he was bleeding from his head and lying on the floor. She went to the nurse station to call EMS and the on-call physician immediately. When Nurse #3 checked Resident #1's bilateral side rails later, she did not find any mechanical malfunctions.

An observation on 02/11/21 at 8:59 AM revealed Resident #1 was lying in the air mattress bed and the bilateral padded full side rails were in the up position. Resident #1 was on droplet/contact precautions and the head of bed was elevated to about 30 degrees.

During a phone interview with Resident #1's RP on 02/11/21 at 11:44 AM, she stated a staff member from the facility called her and reported the fall occurred when the side rail collapsed unexpectedly during incontinence care.

Interview with Nurse #2 on 02/12/21 at 12:49 PM revealed when she assessed Resident #1 on the afternoon of 01/30/21, Resident #1 had 8 staples at left forehead without active bleeding. Nurse #2 stated the staples were removed after 8 days without any complications.

Interview with the Director of Maintenance on 02/11/21 at 11:50 AM revealed he inspected

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 02/16/2021

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 689	Continued From page 4	F 689		

Resident #1's bed rails on the morning of 01/30/21. He unlatched the bed rails to check the mechanism and found that it worked properly. However, he did observe the padding for the side rails tended to slide down and it could interfere with its normal mechanical functions. He recommended to remove the padding each time before sliding the side rail down. He went ahead to check all other side rails in the facility to ensure safety.

A phone interview with Director of Nursing (DON) on 02/11/21 at 12:29 PM revealed in-service related to side rail safety was conducted for all staff after the incident. Staff were educated to remove the padding before sliding the side rails down. The DON stated the fall was caused by the side rail collapsing unexpectedly. She added Resident #1 was observed with seizure activity after the fall but was unsure when it started.

During a phone interview with the Medical Director (MD) on 02/12/21 at 2:14 PM, he stated Resident #1's fall from bed was an isolated incident caused by unexpected collapsing of the side rail. The MD agreed if NA #1 had rolled Resident #1 toward her during the incontinence care, Resident #1 would not have fallen out of bed when the opposite side rail collapsed unexpectedly.