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 ______	01/09/2014

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 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and staff interviews, the facility failed to inform nursing assistants and a physical therapist of new instructions provided by a wound specialist regarding bed mobility and use of a boot for 1 of 2 residents reviewed for treatment of pressure ulcers. (Resident #178) The findings included: 1. Resident #178 was admitted to the facility 12/20/13 with diagnoses which included diabetes mellitus, vascular disease of the lower extremity, and a previous left leg amputation below the knee. An admission Minimum Data Set (MDS) dated 12/27/13 indicated the resident exhibited moderately impaired cognition. The MDS further specified Resident #178 required extensive staff assistance for all care which included assistance of 2 staff members for bed mobility. The MDS identified an unstageable pressure ulcer on the resident's right heel. A Care Area Assessment (CAA) specified the resident was at risk for the development of pressure ulcers due to decreased	F 314	Preparation and/or execution of this polan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Physician's clarification order was obtained for the wound care specialist's recommendation on 1/9/14 for resident #178. CNAs and therapists were inserviced on physician's orders as per the wound care specialist's recommendation for resident #178. Care plan and care card were updated for resident #178 on 1/9/14. Chart reviews were commpleted for all residents that receive the services of the wound care specialist to ensure any recommendations were communicated to the physician for approval and had been implemented. No other variances were	2/5/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/28/2014

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 314	Continued From page 1 mobility and impaired cognition. The CAA identified an unstageable pressure ulcer on the resident's right heel. A care plan dated 01/03/14 specified the resident had an unstageable pressure ulcer on the right heel. The care plan goal was for the ulcer to heal. Interventions included provide assistance to reposition frequently and as needed. The care plan identified nursing assistants as responsible for this intervention. An observation of a Wound Specialist examination of Resident #178's right heel pressure ulcer was conducted 01/08/14 at 3:09 PM. The Director of Nursing (DON) and Corporate Nurse Consultant (CNC) was also present during this examination. The dressing that was removed from the heel revealed the wound had no drainage. The Wound Specialist was observed measuring the size of the pressure ulcer. She stated the ulcer had grown from 4.5 centimeters (cm) in length to 8.5 cm since her last measurement on 12/31/13. The Wound Specialist contributed the increase in size to fluid accumulation in the wound. The Wound Specialist instructed the resident not to use the heel to reposition and push up in the bed. The Wound Specialist explained this caused a shearing affect that would cause the wound to increase in size. These instructions were repeated to the resident several times and the importance of following them was stressed with each repetition. In an interview following this observation, the Wound Care Specialist contributed the increased wound size and fluid accumulation to the resident pushing up in bed with the right heel.	F 314	identified. Nursing Staff and therapist will be re-trained by DON/designee on expectations regarding communication of wound care specialist recommendations. The licensed nurse, that is accompanying the wound care specialist will complete the "Wound recommendation communication form" listing each resident and any new recommendations. The form will be copied and distributed to nurses and therapy department. The charge nurse and Rehab Service Director will convey recommendations to their staff in a timely manner. Care plans and Care cards will be updated by the rounding nurse. DON/designee will utilize a monitoring tool to ensure compliance with wound care specialist recommendations after each weekly visit for four weeks and them monthly for three months. findings will be reviewed in the monthly quality assurance committe meeting for four months for compliance with re-training or additional education provided for any identified concerns. Continued compliance will be monnitored by routine review of the wound care specialis recommendations and through the facility's quality assurance program.	

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F 314	Continued From page 2	F 314		

An interview was conducted with Nursing Assistant (NA) #1 on 01/09/14 at 8:23 AM. NA #1 stated no new instructions regarding bed mobility had been given to her. She stated nursing assistants knew what care a resident required by reading the nursing care card posted inside each resident's closet door.

A review of Resident #178's nursing care card was completed on 01/09/14 at 8:27 AM. No instructions were observed to remind the resident not to push with the right heel while pulling the resident up in bed.

An interview with the DON and CNC was conducted on 01/09/14 at 10:02 AM. The DON stated during her visit on 01/08/14, the Wound Specialist gave Resident #178 instructions not to use the right leg to push up in the bed. The DON acknowledged the Wound Specialist repeatedly advised the resident of this issue. The CNC stated the nursing assistants should have been educated regarding these instructions following the Wound Specialist visit. The DON concurred.

2. Resident #178 was admitted to the facility 12/20/13 with diagnoses which included diabetes mellitus, vascular disease of the lower extremity, and a previous left leg amputation below the knee. An admission Minimum Data Set (MDS) dated 12/27/13 indicated the resident exhibited moderately impaired cognition. The MDS further specified Resident #178 required extensive staff assistance for all care which included assistance of staff with dressing. The MDS identified an unstageable pressure ulcer on the resident's right heel. A Care Area Assessment (CAA) specified the resident was at risk for the development of

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F 314	Continued From page 3 pressure ulcers due to decreased mobility and impaired cognition. The CAA identified an unstageable pressure ulcer on the resident's right heel. A care plan dated 01/03/14 specified the resident had an unstageable pressure ulcer on the right heel. The care plan goal was for the ulcer to heal. Interventions included consult with wound clinic as needed and treatment as ordered by the physician. An observation of a Wound Specialist examination of Resident #178's right heel pressure ulcer was conducted 01/08/14 at 3:09 PM. The Director of Nursing (DON) and Corporate Nurse Consultant (CNC) was also present during this examination. The resident was observed sitting on the bed with a podus boot (a foot boot that helps in the healing of heel pressure ulcers) on the right foot. The podus boot held Resident #178's foot in place to prevent foot drop and was anchored around the right lower leg. The resident was observed assisted with lying down in bed and the Wound Specialist removed the boot. During the examination and treatment of the wound, the Wound Specialist instructed the resident not to wear the podus boot in the bed. The Wound Specialist discussed the issue of not wearing the boot while in bed with the DON and CNC. The Wound Specialist stated she was afraid the podus boot in bed would rub against the back of the resident's lower leg and cause another pressure ulcer. Together they decided to order a different type boot for use in bed. The Wound Specialist did promote the use of the podus boot when out of bed. A review of Resident #178's medical record was	F 314		

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F 314	Continued From page 4 conducted at 8:18 AM on 01/09/14. An order written by the Physical Therapist (PT) on 01/08/14 at 3:30 PM instructed Resident #178 to ware the podus boot in and out of bed as tolerated. An interview was conducted with Nursing Assistant (NA) #1 on 01/09/14. NA #1 stated she was given verbal instructions this morning that Resident #178 was to wear the boot both in and out of bed. She added nursing assistants looked at the nursing care card located inside the closet door in each resident's room to find any special instructions for the resident. A review of Resident #178's nursing care card was completed on 01/09/14 at 8:27 AM. Hand written instructions in the comments section of the care card specified boot on right foot both in and out of bed as tolerated. An interview at this time with Resident #178 confirmed the resident did not wear the boot to bed last evening. An interview was conducted with the PT on 01/09/14 at 8:49 AM. The PT stated the Therapy Manager (TM) had talked with him yesterday about Resident #178 self propelling in the wheel chair and complaining of right heel pain. He stated he had written the order to wear the podus boot in and out of bed to protect the heel ulcer. The PT added no one from nursing had provided any other instructions and he did not talk with the Wound Specialist. An interview was conducted with the TM on 01/09/14 at 9:16 AM. The TM stated it was brought to his attention that Resident #178 was having heel pain with self mobility in the wheel chair. He had instructed PT to find a method to	F 314		

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F 314	Continued From page 5 prevent the resident's heel pain while up in the chair. The TM added no one in nursing had provided any further information. An interview with the DON and CNC was conducted on 01/09/14 at 10:02 AM. The DON stated during her visit on 01/08/14, the Wound Specialist gave Resident #178 instructions not to wear the podus boot in bed. The DON and CNC acknowledged they had no communication with PT after the Wound Care Specialist's visit. Both were unaware of the order written by PT at 3:30 PM on 01/09/14. Both acknowledged the Wound Care Specialist instructions would have been communicated today, 01/09/14, at the daily staff meeting. Both acknowledged prompt communication to therapy following the Wound Care Specialist visit on 01/08/14 should have been provided in this case.	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		2/5/14

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F 441	Continued From page 6 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to correctly disinfect a blood glucose meter after use on 1 of 2 observations of obtaining a finger stick blood sugar. (Resident #110). The findings included: A facility policy entitled Finger Stick Blood Sugar dated 05/2010 specified the effectiveness of the disinfection process depended, in part; on cleaning the outside of the glucometer with an EPA (Environmental Protection Agency) approved germicidal disinfectant. Recommendations for Cleaning and Disinfection	F 441	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ir executed solely because it is required by the provisions of Federal and State law. The glucometer in question was disinfected with an EPA approved germicidal cleaner immediately at the time of citation. Nurse#3 received inservicing on using ther proper EPA germicidal for cleaning glucometers on 1/8/14. Other nurses were inserviced during the timeof survey to ensure understanding of	

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F 441	Continued From page 7 of Glucometers in North Carolina Statewide Program for Infection Control and Epidemiology (undated) specified to disinfect blood glucose meters (glucometers) after each use using an EPA (Environmental Protective Agency) -registered detergent/germicide with a tuberculocidal or Hepatitis B Virus/Human Immune Virus label claim ....Alcohol is not an EPA-registered detergent/disinfectant. An observation of Nurse #3 obtaining a finger stick blood sugar on Resident #110 was conducted on 01/08/14 at 11:39 AM. Following the procedure, Nurse #3 was observed wiping the blood glucose meter with an alcohol disposable wipe. Nurse #3 ensured the entire surface of the meter was wiped. She then threw the alcohol disposable wipe away, removed her gloves, and placed the glucometer on a dry paper towel on top of the medication cart. During an interview following the observation, Nurse #3 stated she used alcohol to clean the glucometer. During an interview with Nurse #3 on 01/08/14 at 4:25 PM, the nurse stated she knew she used an alcohol wipe to clean the glucometer because the germicidal disinfectant was not on her medication cart. Nurse #3 further revealed she should have used the germicidal disinfectant to clean the glucometer. During an interview with Nurse #4 on 01/08/14 at 4:29 PM, the nurse stated germicidal disinfectant was stored on each medication cart in the bottom drawer. An interview on 01/09/14 at 12:25 PM with the Administrator and the Corporate Nurse Consultant revealed the expectation was to use a	F 441	glucometer cleaning. Licensed nurses will be inserviced on the protocol for cleaning glucometers. Nurses on hire will be required to do a return demonstration on cleaning glucometers to validate understanding. DON/designee will utilize a monitoring tool for return demonstration for all licensed nurses on cleaning glucometers to validate understanding. Random monthly med passes will include the observation of glucometer cleaning utilizing a monitoring tool. Any variances will be corrected at the time of observation. Findings will be reviewed by the facility's quality assurance committee monthly meetings for three months. Continued compliance will be monitored by routine random observations of glucometer cleaning and through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 441	Continued From page 8 germicidal product to disinfect the glucometer.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to document findings and treatment of skin issues for 1 of 2 residents reviewed for pressure ulcer prevention and treatment. (Resident #178). The findings included: Resident #178 was admitted to the facility 12/20/13 with diagnoses which included diabetes mellitus, vascular disease of the lower extremity, and a previous left leg amputation below the knee. A review was conducted of Resident #178's nurse's admission assessment dated 12/20/13 and signed by Nurse #1. An anatomical diagram	F 514	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soleyl because it is required by the provision of Federal and State law. Resident #178 was discharged from the facility to home on 1/18/14. Chart reviews were completed for all residents that have wound or skin issues. No issues in documentation identified. Licensed nurses will be inserviced by the DON/designee regarding documenting findings and treatments of skin issues. Any skin issues are to be documented on	2/5/14

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F 514	Continued From page 9 on page 1 of the document contained markings that indicated where skin issues were located. A circle on the right heel was labeled "soft, mushy." A review of a nursing note dated 12/20/13 and signed by Nurse #1 revealed no mention of the right heel with soft, mushy skin. An admission Minimum Data Set (MDS) dated 12/27/13 indicated the resident exhibited moderately impaired cognition. The MDS further specified Resident #178 required extensive staff assistance for all care which included assistance of 2 staff members for bed mobility. The MDS identified an unstageable pressure ulcer on the resident's right heel. A Care Area Assessment (CAA) specified the resident was at risk for the development of pressure ulcers due to decreased mobility and impaired cognition. The CAA identified an unstageable pressure ulcer on the resident's right heel. Continued medical record review revealed nursing notes did not address Resident #178's right heel skin issue until 12/30/13. A physician's order dated 12/30/13 specified a povidone-iodine solution was to be applied twice a day to the resident's right heel and the heel was to be covered with a sterile dressing. A nursing note dated 12/30/13 indicated the new physician's order had been noted. A care plan dated 01/03/14 specified the resident had an unstageable pressure ulcer on the right heel. The care plan goal was for the ulcer to heal. Interventions included treatment as ordered. An interview with Nurse #1 was conducted via	F 514	the skin assessment (admission and/or weekly). Physicians orders to be obtained for treatment as per wound protocol and documented on the residents treatment administration record. Skin issues will be communicated via the 24 hour report sheet. A monitoring tool will be utilized by the DON/designee to review new residents on admission for any skin issues to ensure that findings and treatments are documented. All residents identified with wound issues will be reviewed with the monitoring tool during daily clinical meeting for four weeks and then monthly for three months to ensure that skin issue findings and treatments are documented. Findings will be reviewed by the facility's quality assurance committee monthly for four months for continued compliance. Additional education and monitoring will be initiated for any identified concerns.	

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F 514	Continued From page 10	F 514		

phone on 01/07/14 at 8:09 PM. Nurse #1 stated she admitted Resident #178 to the facility on 12/20/13. The nurse did recall the resident's right heel felt soft and mushy when examined. Nurse #1 did not recall making a note of that in the resident's medical record or on the 24 hour report kept on the nursing unit. She stated facility expectations for prevention of a heel pressure ulcer was to apply a povidone-iodine skin prep (an agent that promotes hardening of the skin) to prevent skin breakdown. Nurse #1 added she applied the skin prep to the heel and did verbally pass the information to the nurse on the following shift. Nurse #1 stated she should have written the application of skin prep on the treatment administration sheet (TAR) but did not.

An interview was conducted with Nurse #2 on 01/08/14 at 6:54 AM. Nurse #2 stated Nurse #1 verbally reported Resident #178's right heel skin issue when she relieved Nurse #1 on the evening of 12/20/13. Nurse #2 stated she applied povidone-iodine skin prep to the resident's right heel as facility protocol dictated but did not chart it in the medical record. Nurse #2 added she observed a blister on the heel during the night shift on 12/29/13. On the morning of 12/30/13, she reported the new finding to her relief nurse that obtained the order for povidone-iodine solution application twice a day and to cover the heel wound with a sterile dressing.

An interview was conducted with the Administrator on 01/09/14 at 10: 39 AM. The Administrator explained the facility had physician approved protocols that included pressure ulcer prevention and wound care. If a nurse needed to implement a protocol that required use of a dressing, that protocol was written as a

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F 514	Continued From page 11 physician's order and placed on the TAR. If a protocol was used for prevention as in the instance of soft, mushy heels requiring skin prep, the protocol was not expected to be written on the TAR. The Administrator stated when Resident #178 was assessed with a soft, mushy right heel, the information should have been written on the 24 hour report. An interview was conducted with the Director of Nursing (DON) on 01/090/14 at 12:26 PM. The DON stated 24 hour reports from 12/20/13 were reviewed. There was no documentation regarding Resident #178's mushy right heel. She added the 24 hour reports should provide information needed for resident care. The DON explained nurses that had been off were expected to review the reports to promote continuity of care.	F 514		