STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. BUILDING _____ B. WING _____	C 07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews, and resident and staff interviews the facility failed to assess residents regarding their preference for frequency of showers per week for 2 of 2 residents reviewed for choices (Resident #59 and #119). The findings included: 1. Resident #59 was admitted on 05/16/15 with diagnoses including diabetes mellitus and cellulitis. Review of the admission Minimum Data Set (MDS) dated 05/30/15 revealed Resident #59 was cognitively intact and totally dependent on staff with bathing. Review of the Care Area Assessment (CAA) Summary for Activity of Daily Living (ADL) Functional/Rehabilitation Potential dated 06/03/15 stated Resident #59 was admitted for short term rehabilitation due to cellulitis and venous insufficiency. The CAA Summary noted Resident #59 required staff assistance with activities of daily living. Review of a care plan dated 07/27/15 revealed Resident #59 required assistance with activities	F 242	The Laurels of Hendersonville wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is 08/21/2015. 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 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. 1. Residents #59 and #119 were assessed regarding their preference for frequency of showers per week. Residents #59 and #119 are now provided 3 showers per week based on resident preference. 2. All current residents and/or responsible parties will be assessed regarding their preference for frequency of showers per week. Shower schedules will be revised	8/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/05/2015

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F 242	Continued From page 1 of daily living related to cellulitis and recurrent illness. The goal was for Resident #59 to be able to shower and bathe with assistance through the next review on 09/01/15. During an interview on 07/27/15 at 3:01 PM Resident #59 stated she received assistance with two showers every week on Wednesday and Saturday but would like to have three showers a week. Resident #59 further stated no one had asked her how many times a week she would like a shower. An interview with Nurse Aide (NA) #1 on 07/29/15 at 3:05 PM revealed residents received two showers a week which were scheduled by the resident's room number. NA #1 stated if a resident requested another shower they would try and accommodate the request. During an interview on 07/30/15 at 8:44 AM NA #2 confirmed she was on the shower team and stated residents received two showers a week which were scheduled by the resident's room number. NA #2 further stated she informed new admissions what two days they were scheduled for showers and asked them if they wanted a morning or afternoon shower. An interview with Unit Manager (UM) #2 on 07/30/15 at 12:49 PM revealed the nursing admission assessment did not include assessing a residents preference regarding frequency of showers per week. UM #2 stated the NAs informed new admissions what two days they were scheduled for showers. During an interview on 07/30/15 at 1:41 PM the Director of Nursing (DON) stated her expectation	F 242	based on the assessed preference for frequency of showers per week. All newly admitted residents and/or responsible parties will be assessed regarding their preference for frequency of showers per week. Frequency of showers will be assessed and provided based on resident preference. 3. All facility staff will be in-serviced by SDC regarding the resident right to make choices with a focus on preference for frequency of showers per week. The in-service content will also include the facility policy to provide showers based on resident preference. A QA monitoring tool will be utilized to ensure ongoing compliance with resident preference for frequency of showers per week. The QA monitoring tool will be completed 5 times per week x 2 weeks, then 3 times per week x 2 weeks, then 2 times per month x 2 months, to ensure that preference for frequency of showers is being assessed and honored. 4. Results of the QA monitoring tool will be reported to the QA Committee monthly x 3 months or until resolved by the QA Committee. Additional in-servicing will be provided as needed for continued compliance.	

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F 242	Continued From page 2	F 242		

was for residents to have the number of showers they preferred every week but this was not currently assessed by the facility. The DON indicated the shower schedule assigned residents two showers a week by room number. The DON thought the activity assessment might include assessing a residents preference regarding frequency of showers per week.

An interview was conducted with the Activity Director on 07/30/15 at 3:05 PM. The Activity Director stated her assessment included asking residents if they wanted a tub bath or a shower but did not include asking them how many showers or baths they wanted every week. The Activity Director further stated if a resident asked her about showers she told then they received two showers a week but did not know what days they would be scheduled on.

2. Resident #119 was admitted on 07/09/15 with diagnoses including recent pneumonia and hypoxic respiratory failure. Review of an admission Minimum Data Set (MDS) dated 07/16/15 revealed Resident #119 was cognitively intact and required extensive assistance with bathing.

Review of the Care Area Assessment (CAA) Summary for Activity of Daily Living (ADL) Functional/Rehabilitation Potential dated 07/22/15 stated Resident #119 was admitted for short term rehabilitation due to recent pneumonia and sepsis. The CAA Summary noted Resident #119 required staff assistance with activities of daily living.

Review of a care plan dated 07/23/15 revealed Resident #119 required assistance with activities

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F 242	Continued From page 3	F 242		

of daily living related to recurrent pneumonia, chronic pain, respiratory deficits, and medication side effects. Interventions included offering two showers a week.

During an interview on 07/27/15 at 2:00 PM Resident #119 stated she preferred three showers a week but when she asked on admission she was told she would receive two showers a week.

An interview with Nurse Aide (NA) #1 on 07/29/15 at 3:05 PM revealed residents received two showers a week which were scheduled by the resident's room number. NA #1 stated if a resident requested another shower they would try and accommodate the request.

During an interview on 07/30/15 at 8:44 AM NA #2 confirmed she was on the shower team and stated residents received two showers a week which were scheduled by the resident's room number. NA #2 further stated she informed new admissions what two days they were scheduled for showers and asked them if they wanted a morning or afternoon shower.

An interview with Unit Manager (UM) #2 on 07/30/15 at 12:49 PM revealed the nursing admission assessment did not include assessing a residents preference regarding frequency of showers per week. UM #2 stated the NAs informed new admissions what two days they were scheduled for showers.

During an interview on 07/30/15 at 1:41 PM the Director of Nursing (DON) stated her expectation was for residents to have the number of showers they preferred every week but this was not

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F 242	Continued From page 4 currently assessed by the facility. The DON indicated the shower schedule assigned residents two showers a week by room number. The DON thought the activity assessment might include assessing a residents preference regarding frequency of showers per week. An interview was conducted with the Activity Director on 07/30/15 at 3:05 PM. The Activity Director stated her assessment included asking residents if they wanted a tub bath or a shower but did not include asking them how many showers or baths they wanted every week. The Activity Director further stated if a resident asked her about showers she told then they received two showers a week but did not know what days they would be scheduled on.	F 242		
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. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		8/21/15

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F 441	Continued From page 5 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, record reviews, and staff interviews the facility failed to disinfect a blood glucose meter (used for blood sugar monitoring) according to manufacturer's recommendations for 1 of 1 finger stick blood sugars observed during medication administration (Resident #135). A review of the label on the germicidal disposal wipe container indicated to unfold wipe and thoroughly wet surface of glucometer. Use additional wipe (s) if needed to assure continuous 2 minute wet contact time and let air dry. Manufacturer's recommendations indicated germicidal wipes could be used to disinfect blood glucose meter. A record review of the facility document dated 07/18/14 entitled Glucometer Cleaning Procedure	F 441	1. The blood glucose meter (glucometer) used to obtain a finger stick blood sugar for Resident #135 was disinfected again by following manufacturer¿s recommendations. No negative outcome resulted. 2. All other glucometers used for finger stick blood sugars were disinfected by following manufacturer¿s recommendations. No negative outcome resulted. 3. SDC and/or designee will in-service all licensed nursing staff regarding the manufacturer¿s recommendations and proper procedure for disinfecting glucometers.	

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F 441	Continued From page 6 indicated (in part) in order for the cleaning process to be effective the following steps must be followed: · 3. Use one sani-cloth towelette to clean all surfaces of the glucometer. · 4. Use another sani-cloth towelette to wrap around the glucometer and place wrapped glucometer on paper towel or in a cup. · 5. Let glucometer remain in the moist towelette for 2 minutes (this time frame will ensure the efficiency of disinfection). · 6. Remove wrapping and let the glucometer air dry before use. This process is to be followed for each use of all glucometers. During a continuous observation on 07/28/15 at 4:08 PM Nurse #1 picked up a glucometer from the top of the medication cart and carried it into Resident #135's room and performed a finger stick blood sugar. Nurse #1 then left Resident #135's room and walked back to the medication cart in the 100 hallway and laid the glucometer down on the medication cart. Nurse #1 wrote a note on Resident #135's medication administration record. Nurse #1 then picked up the glucometer and took a germicidal wipe from a container on the medication cart and wiped briefly across the front and back of the glucometer using one wipe and then tossed the wipe in the trash. Nurse #1 then set the glucometer down on the top of the medication cart and indicated she was ready to use the glucometer to obtain a blood sugar on another resident. On 07/28/15 at 4:20 PM an interview was conducted with Nurse #1 who stated her usual routine was to wipe the glucometer machine down with germicidal wipe for less than 1 minute between residents because she had several	F 441	After in-service is complete, each licensed nurse will be tested by the SDC and/or designee for return demonstration of proper procedure for disinfecting glucometers per manufacturer¿s recommendations. Each licensed nurse will be in-serviced upon hire, annually, and as needed regarding manufacturer¿s recommendations and proper procedure for disinfecting glucometers for continued compliance. A QA monitoring tool will be completed by Unit Manger and/or designee 10 times per week x 2 weeks, then 5 times per week x 2 weeks, then monthly x 3 months or until resolved by the QA Committee. This audit tool will include the Unit Manager and/or designee observing the licensed nurse disinfecting the glucometer per manufacturer¿s recommendations to ensure proper procedure is followed. 4. Results of the QA monitoring tool will be reported to the QA Committee monthly x 3 months and ongoing until resolved by the QA Committee to ensure continued compliance with further education, monitoring, or appropriate action if indicated.	

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F 441	Continued From page 7 blood sugars to obtain. Nurse #1 stated when she was completed with obtaining all resident's blood sugars then she would wrap the glucometer in germicidal wipe for 2 minutes and then let air dry. Nurse #1 revealed she had not let the germicidal wipe make wet contact with the glucometer for 2 minutes and air dry as per manufacturer's instructions before she prepared to use the glucometer on another resident. Nurse #1 stated she had received in-service education from the facility on how to disinfect the glucometer. On 07/28/15 at 5:11 PM an interview was conducted with Unit Manager #1 who stated the glucometer was to be wiped down with germicidal wipe (s) by nursing staff after use on each resident. The germicidal wipe was to have wet contact with the glucometer for 2 minutes and then allowed to air dry prior to using the glucometer on another resident. On 07/28/15 at 5:28 PM an interview was conducted with the Director of Nursing (DON) who stated her expectations were that nurse would have followed the facility policy and procedure and manufacturer's recommendations for disinfecting the glucometer between residents. The DON stated the glucometer needed to have wet contact for 2 minutes with germicidal wipe and then air dried prior to use on another resident. The DON stated nursing staff had been in serviced on disinfecting the glucometer.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		8/21/15

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F 520	Continued From page 8 assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. 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 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. This failure related to one deficiency which was originally cited during the facility's 07/10/14 recertification survey, and was recited during the facility's current recertification survey. The recited deficiency was in the area of infection control. The Facility's continued failure during two consecutive recertification surveys shows a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 520	1. The blood glucose meter (glucometer) used to obtain a finger stick blood sugar for Resident #135 was disinfected again by following manufacturer¿s recommendations. No negative outcome resulted. 2. Current and future residents who require a glucometer to obtain a finger stick blood sugar have the potential to be affected. 3. The QA Committee will be in-serviced by the Administrator on the procedures for	

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F 520	Continued From page 9 Findings included: This tag is cross referred to: 1. F 441: Infection Control: Based on observation, record reviews, and staff interviews, the facility failed to disinfect a blood glucose meter (glucometer used for blood sugar monitoring) according to manufacturer's recommendations for 1 of 1 finger stick blood sugars observed during medication administration (Resident #135). During the recertification survey of 07/10/15 the facility was cited for failing to disinfect a blood glucose meter (glucometer used for blood sugar monitoring) according to manufacturer's recommendations. During the recertification survey of 07/10/14 the facility failed to follow manufacturer's instructions to disinfect a glucose meter (glucometer) for 1 of 1 resident observed for finger stick blood sugars (Resident #3). On 07/30/15 at 2:00 PM an interview with the Administrator was conducted regarding the facility's Quality Assessment and Assurance (QAA) Committee. The Administrator revealed the facility's QAA committee meetings were held monthly. He stated what led to being back out of compliance regarding the disinfection of glucometers was the facility failed to provide more ongoing education and more consistent compliance with the disinfection of glucometers. He stated expectation of staff from this point would be to correct the deficiency, monitor the glucometer disinfection, and monitor the correction is sustained, and have continued compliance. He further stated staff are expected to follow policy and procedures for disinfecting the glucometers.	F 520	developing and implementing appropriate plans of action to correct identified quality 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 monthly x 3 months by the Administrator and/or designee to ensure the committee is developing and implementing appropriate plans of action to correct quality concerns. Variances will be corrected and/or additional education provided when indicated. 4. The Administrator and/or designee will review the results of the QA monitoring tool with the QA Committee monthly x 3 months then randomly thereafter to ensure continued compliance.	