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 02/01/2023

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 An unannounced complaint investigation survey was conducted from 02/01/23 through 02/01/23. One of two complaint allegations resulted in a deficiency. NC00197224. Event ID# 3OJ511.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of	F 623		2/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/23/2023

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 623	Continued From page 1 this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and	F 623		

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F 623 — Continued From page 2

email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to provide notification for discharge for 1 of 1 sampled resident (Resident #1) for notification requirements before transfer/discharge.

Findings included:

Resident #1 was admitted to the facility on 10/01/22 and discharged on 01/13/23 to an assisted living facility. Diagnoses included type 2 diabetes, stage 4 pressure ulcer of right buttock, and hypertensive heart disease without heart failure.

F 623 (Provider's Plan of Correction)

F623

The facility will continue to provide guests with notification to meet the requirements before transfer/discharge.

Resident #1 no longer resides in the facility.

Current residents that are to be discharged from the facility to a lesser level of care have the potential to be affected. An audit was completed by the Regional Clinical Coordinator on 2/22/23

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F 623	Continued From page 3 Review of revised facility discharge/transfer policy dated 08/31/22 read in part: "when an anticipated discharge is scheduled, the post-discharge plan of care and summary is developed prior to discharge. Social services/ designee reviews the plan with the resident at least 24-hours prior to discharge." Review of the discharge Minimum Data Set (MDS) dated 01/13/23 revealed Resident #1 was cognitively intact. Review of the Nurse Practitioner (NP) note dated 01/13/23 revealed Resident #1's potassium level was stabilized, and she was safe for discharge with recommendations of physical therapy, occupational therapy, nursing assistance and services for disease and medication management as ordered. Resident #1 was unable to leave home without assistance and follow up with medical doctor in one week, sooner if needed. Hard scripts provided. Review of the nursing note written by Nurse #1 dated 01/13/23 revealed Resident #1 discharged home at 10:00 AM by car with caseworker/friend. Paperwork was signed by Resident #1 and prescriptions were given to the resident. An interview conducted with Nurse #1 on 02/01/23 at 12:47 PM revealed she was familiar with Resident #1 and had been responsible for completing her discharge paperwork on 01/13/23. She stated Resident #1 had labs completed on 01/12/23 and results showed her bloodwork to be stable and she was able to be discharged on 01/13/23. Nurse #1 revealed she was informed of Resident #1's discharge around 9:00 AM on	F 623	including all residents that have been discharged for the month of February. No negative outcomes were identified relating to the audit. The Administrator, Social Worker, Business Office Manager, and all licensed nurses will be in-serviced by the ADON on the facility policy for Transfers and Discharge planning by 2/24/23. This task was completed by all staff mentioned above before 2/24/23 so all were able to work as education had already been completed. We have no agency staff, so there weren't any that needed the education. A QA monitoring tool will be utilized to ensure that notification is provided prior to transfer/discharge beginning on 2/27/23. The DON or designee will audit records for all pending discharges weekly x 12 weeks and bring the results to QA. Variances will be corrected at the time of the audit and additional education provided when indicated. Audit results will be reported the Administrator weekly for the next 3 months beginning on 3/6/23 and concerns will be reported to QA committee by the DON or designee during monthly meetings. Continued compliance will be monitored through the facilities QA assurance program. Compliance will be monitored by the QA committee for 3 months or until resolved	

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F 623	Continued From page 4 01/13/23 and completed and reviewed the facility discharge/transfer summary with Resident #1 and provided her with a copy along with a hard script for medication to be given to the assisted living facility. She stated no knowledge of Resident #1 being notified of discharge prior to 01/13/23. An interview conducted with the Unit Manager on 02/01/23 at 01:21 PM revealed she was familiar with Resident #1 and her discharge on 01/13/23. She stated she was informed around 9:00 AM on 01/13/23 during morning meeting, Resident #1 was being discharged back to the assisted living facility due to her labs taken day before being normal. She revealed nursing completed and reviewed the discharge summary with Resident #1 and provided her with a copy along with a hard script for medications to be given to the assisted living facility. She stated no knowledge of Resident #1 being notified prior to the morning of 01/13/23 of discharge to assisted living facility. An interview conducted with the Business Office Manager on 02/01/23 at 2:02 PM revealed she was out of the facility on 01/13/23 when Resident #1 was discharged and had not been made aware of possible discharge prior and to her knowledge Resident #1 had not discussed or received notification of discharge prior to the morning of 01/13/23. An interview conducted with the Social Worker on 02/01/23 at 2:18 PM revealed she was familiar with Resident #1. She stated she was normally responsible for resident discharge which would include speaking with residents about their upcoming discharge prior to being discharged and reviewing a discharge plan, but Resident #1's discharge was done quickly the morning of	F 623	and additional education training will be provided for any issues identified. This will be complete by 2/24/23 and audits will run through May 15, 2023.	

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F 623	Continued From page 5 01/13/23 and to her knowledge was being handled by the business office and the administrator. The social worker stated Resident #1 did not have a scheduled discharge and she did not notify Resident #1 about her discharge and to her knowledge notification was not given to Resident #1 about her discharge until the morning of 01/13/23. An interview with the Administrator on 02/01/23 at 4:00 PM revealed she was familiar with Resident #1 and her discharge to assisted living facility. She stated they did not have set date for Resident #1's discharge until the morning of 01/13/23 although discharge back to assisted living facility had been the plan since her admission. She revealed to her knowledge Resident #1 had not been notified of discharge or possible discharge until the morning of 01/13/23.	F 623		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Director of Assisted Living Facility interviews, the facility failed to notify and provide discharge paperwork to the assisted living facility and to schedule a Home Health referral to provide wound care for 1 of 1 sampled resident (Resident #1) for safe and	F 624	F624 The facility will continue to provide and document sufficient preparation and orientation to the residents to ensure a safe and orderly transfer/discharge.	2/24/23

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F 624	Continued From page 6 orderly discharge to an assisted living facility. Findings included: Resident #1 was admitted to the facility on 10/01/22 and discharged on 01/13/23 to an assisted living facility. Diagnoses included type 2 diabetes, stage 4 pressure ulcer of right buttock, and hypertensive heart disease without heart failure. Review of the discharge Minimum Data Set (MDS) dated 01/13/23 revealed Resident #1 was cognitively intact. An interview conducted with Nurse #1 on 02/01/23 at 12:47 PM revealed she was familiar with Resident #1 and had been responsible for completing her discharge paperwork on 01/13/23. She stated she was informed of Resident #1's discharge on 01/13/23 and completed and reviewed the facility discharge/transfer summary with Resident #1 and provided her with a copy along with a hard script for medication to be given to the assisted living facility. She revealed that she did not complete a referral for home health to provide wound care at the assisted living and did not speak to anyone at the assisted living facility about Resident #1 being discharged. She stated when she tried to call later that day to give report on Resident #1, she was placed on hold and hung up before speaking with anyone. Nurse #1 stated the Social Worker or Unit Manager was responsible for scheduling resident discharges and speaking with the receiving facility and she was not aware the assisted living facility had not been told about Resident #1's discharge. An interview conducted with the Unit Manager on	F 624	Resident #1 no longer resides in the facility. Residents that are returning to the community or a lesser level of care have the potential to be affected. An audit was completed by the Regional Clinical Coordinator on 2/22/23 including all residents that have been discharged for the month of February. No negative outcomes were identified relating to the audit. The Administrator, Social Worker, Business Office Manager, and all licensed nurses will be in-serviced by the ADON on preparation for safe and orderly discharge/transfer by 2/24/23. All education was completed by the above mentioned staff so all were able to continue working. We have no agency in the building at this time so no education was provided. A QA monitoring tool will be utilized to ensure that proper preparations are made for discharge/transfers beginning on 2/27/23. The DON/designee will audit records for all pending discharges weekly x 12 weeks. Variances will be corrected at the time of the audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3/6/23 and concerns reported to the QA committee by the DON/designee during monthly meetings.	

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F 624	Continued From page 7 02/01/23 at 01:21 PM revealed she was familiar with Resident #1 and her discharge on 01/13/23. She stated she was informed around 9:00 AM on 01/13/23 during morning meeting, Resident #1 was being discharged back to the assisted living facility. She revealed nursing completed and reviewed discharge summary with Resident #1 and provided her with a copy along with a hard script for medications to be given to the assisted living facility and she was not aware of anyone making a referral for Home Health to provide wound care at the assisted living facility. The Unit Manager stated prior to Resident #1's discharge the business office had spoken with assisted living facility about payment and they had requested to speak with someone from nursing for an update on Resident #1 and she attempted to call the assisted living facility and was sent to wrong department and placed on hold and hung up without speaking to anyone. She revealed to her knowledge she believed the assisted living facility had been notified of Resident #1's discharge and paperwork had been faxed by Social Worker who was responsible for resident discharge. An interview conducted with Business Office Manager on 02/01/23 at 2:02 PM revealed she was familiar with Resident #1. She stated she had spoken with assisted living facility either on 01/04/23 or 01/11/23 about Resident #1's payee status and payment due to her Medicare days ending. She revealed the assisted living facility agreed to take Resident #1 back once she was ready for discharge and had asked for a status update. The Business Office Manager stated she informed the assisted living facility that she was not knowledgeable of Resident #1's clinical status, and she could only read off her current	F 624	Continued compliance will be monitored through the facility's QA program. Compliance will be monitored by the QA committee for 3 months or until resolved and additional education is provided for any issues identified. This will be completed by 2/24/23 and audits will be completed by May 15, 2023.	

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F 624	Continued From page 8	F 624		

orders and the assisted living facility asked if someone from clinical could contact them to update them on Resident #1's status. She revealed there was no discharge dates discussed with the assisted living facility and she informed the Unit Manager and Social Worker of the phone call with the assisted living facility and their request for someone from clinical to update them on Resident #1's status. She stated she was out of the facility on 01/13/23 when Resident #1 was discharged and had not been made aware of possible discharge prior and had not informed the assisted living facility of possible discharge on 01/13/23.

An interview conducted with the Social Worker on 02/01/23 at 2:18 PM revealed she was familiar with Resident #1. She stated she was normally responsible for resident discharge which would include speaking with receiving facility prior to date of discharge, faxing over all paperwork, making referrals for any services or appointments needed, and confirming the facility had received the fax. She revealed Resident #1's discharge was done quickly the morning of 01/13/23 and to her knowledge, was being handled by the business office and the Administrator. The Social Worker stated she did not speak with anyone from the assisted living facility about Resident #1's discharge and did not fax over any paperwork until after Resident #1 had been discharged and assisted living facility had called stating they were not aware of the discharge and had no paperwork for Resident #1 to include referral for home health to provide wound care. She revealed she believed issues with Resident #1's discharge was due to miscommunication and believing other staff had spoken with the assisted living facility and taken care of discharge

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F 624	Continued From page 9 details. Telephone interview conducted with Director of the Assisted Living Facility on 02/01/23 at 2:54 PM revealed she was familiar with Resident #1. She stated she had received a telephone call from the Business Office Manager at the skilled nursing facility a week or two weeks prior to Resident #1's discharge discussing her payee status and asking if they would take her back when she was ready for discharge. She revealed she asked about a discharge date and the Business Office Manager did not have a discharge date available and she then asked for an update on her status and requested someone from clinical staff contact her with a status update. The Director of the Assisted Living Facility stated she heard nothing back from the facility and received no paperwork. She revealed on 01/13/23 she received a telephone call from Resident #1 stating she had been discharged from the skilled nursing facility and was in the parking lot and needed someone to bring her some shoes because she only had socks to wear. She stated she immediately called the skilled nursing facility and spoke with the Administrator about not being notified of Resident #1's discharge and not having any paperwork for Resident #1 to include a current FL2, medication administration record, medication orders, progress notes, information on wound care, and no referral for home health to provide wound care. The Director of the Assisted Living Facility revealed the Administrator stated the assisted living facility had spoken with their Business Office Manager a week or two ago about finances and she believed their facility had tried to contact the assisted living facility yesterday about the discharge yesterday and was unable to speak	F 624		

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F 624	Continued From page 10 with anyone. She stated the Administrator offered to fax over all the needed paperwork and then hung up before receiving correct fax number and she had to call back and give correct fax number. She revealed her facility was able to provide medications for Resident #1 by using their back-up pharmacy until her medications could be filled and delivered from pharmacy and her nursing staff provided wound care for Resident #1 until a referral for home health could be scheduled for the following Monday. The Director of the Assisted Living stated Resident #1's discharge was unsafe and they should have been notified of her pending discharge date prior to her discharge and been able to discuss her status, medications, and treatments needed. An interview with the Administrator on 02/01/23 at 4:00 PM revealed she was familiar with Resident #1 and her discharge to the assisted living facility. She stated to her knowledge the Business Office Manager had spoken with the assisted living facility prior to Resident #1's discharge on 01/13/23 and discussed if they would be willing to take Resident #1 back when ready for discharge to which they agreed and payment status. She revealed they did not have a set date for Resident #1's discharge until the morning of 01/13/23 and to her knowledge she believed staff had attempted to contact the assisted living facility and was unable to speak with anyone. The administrator stated she was not aware the assisted living facility had not received discharge paperwork for Resident #1 until after she was discharged, and the assisted living facility called, and she offered to fax needed paperwork to them immediately. She revealed the Social Worker was responsible for discharges and she assumed all details for discharge had been taken care of and	F 624		

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F 624	Continued From page 11 was not aware the assisted living facility had not been notified of discharge. The Administrator stated discharge protocol should have been followed and the assisted living facility should have been notified and discharge paperwork sent prior to discharge.	F 624		