PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-0391

1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345303	B. WING _			12/	07/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
l				70	SWEETEN CREEK ROAD		
THE LAUF	RELS OF GREENTREE R	IDGE		AS	SHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
F 600 SS=D	conducted on 12/05/2 obtained through 12/0 date is 12/07/23. Eve intakes were investigated NC00210809. Three in deficiencies. Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom fro Exploitation The resident has the neglect, misapproprial and exploitation as defincludes but is not limitation.	m Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This	F	600			1/3/24
	any physical or chem treat the resident's method with the resident with the resident's method with the resident	ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or ; is not met as evidenced			The facility will continue to ensure all		
	Resident, Physician A Health Care Personn interviews, the facility vulnerable female res inappropriate intimac; (Medication Aide #1) for abuse. On or arou alleged Medication Ai mouth.	sident (Resident #1) from			The facility will continue to ensure all vulnerable residents are protected from inappropriate intimacy from employees Resident #1 has had no identified negative outcomes because of this allegation and continues to be seen routinely for psychiatric/psychological services. Current vulnerable residents have the potential to be affected. From		(X6) DATE

Electronically Signed 01/02/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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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	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		345303	B. WING		1	C 2/07/2023
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/07/2023
	10115211 011 001 1 2.2.1			70 SWEETEN CREEK ROAD		
THE LAUF	RELS OF GREENTREE R	RIDGE				
				ASHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	Continued From page	e 1	F 60			
	The findings included	l:		12/6/23-12/9/23 the nursing additeam conducted interviews with residents that have a BIMs of 1	all	
	Resident #1 was adm	nitted to the facility on		greater (cognitively intact) to de	termine if	
		ses that included diabetes		they felt safe in the facility. The		
	mellitus, anxiety, dep	ression and post-traumatic		issues identified. No residents r	eported	
	stress disorder.			inappropriate sexual advances		
				Aide #1 or any other staff meml		
		ation. Resident #1 was her		Between 12/25/23-12/29/23 the		
	own responsible part	y.		nurse conducted skin assessme		
	T. () 84' '	D (0 ((MD0)		of the residents that had BIMS		
	The quarterly Minimu			than 13 to determine if there we		
	assessment dated 08	nitively intact. The Resident		signs of abuse. No issues were On 12/29/23 the Reginal Clinica		
	was able to understa			Coordinator re-educated the fac		
		no behaviors such as		Administrator and the Assistant	-	
		sical or verbal aggression		Nursing on the abuse policy and		
		or delusions during the		procedure. The education empl		
	MDS assessment pe			resident□s right to be free from		
	•			Definitions and types of abuse,		
	A review of Resident	#1's care plan initiated on		of abuse, identification of abuse	e, and	
	09/26/19 and revised	on 05/12/23 addressed the		protecting residents from abuse	were	
	area of:			reviewed as well as reporting ex	•	
		ing irrational thoughts		from the state operations manu		
		and physician having an		100% of facility staff were in-se	•	
	•	because she had been in		the Administrator, Assistant Dire		
		an since she had been in the		Nursing on the abuse policy and		
		s that Resident #1 would		procedure. The education empl		
	· ·	n making regarding care to		resident □s right to be free from		
		ntrol and she would be free		Definitions and types of abuse,	•	
		nviors through the next need by interventions which		of abuse, identification of abuse protecting residents from abuse		
	included referring to			reviewed as well as reporting e		
	moraded referring to p	ooyoniaa y.		from the state operations manu		
	On 12/04/23 at 9:55	AM an interview was		education began on 12/29/23 w		
		ealth Care Personnel		education to be completed by 1		
		ho reported she went to the		Newly hired employees after 1/2		
	_ , ,	review the personnel files of		receive mandatory in person ed		
	-	d Aide) #1 and interview the		the Assistant Director of Nursing	-	

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CENTERS FOR MEDICARE & MEDICAID SERVICES		MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
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NAME OF D	ROVIDER OR SUPPLIER	0.0000		etheet vindess (CITY, STATE, ZIP CODE	12/07/2023
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THE LAUF	RELS OF GREENTREE R	IDGE		70 SWEETEN CREE		
				ASHEVILLE, NC	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH (VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BI JEFERENCED TO THE APPROPRIA DEFICIENCY)	
F 600	Continued From page	<u>.</u> 2	F 6	00		
. 000	· ·				tation prior to the start of	
		urrent investigation at a		-	tation prior to the start of	
		plained that she interviewed			t. The education will	
		ector of Nursing (DON), and			resident⊡s right to be free	;
		1 at the facility and from the ere could have been an			Definitions and types of	on .
		ship between Med Aide #1			ention of abuse, identification of protecting residents from	
		HCPI continued to explain			eviewed as well as reporti	
		reported Med Aide #1 was			m the state operations	iiig
		er facility because he had		manual.	in the state operations	
		dent by being an active			ring tool will be utilized to	
		was going through some			ing compliance beginning	on
	family dynamics and				ADON/designee will screer	
		with the staff and he had not			t may be more vulnerable/	
	_	he DON explained that she			for inappropriate staff to	
	_	a Performance Improvement			actions through MDS	
	Plan (PIP) with Med A				bservations by the Assista	nt
	, ,	ions with female staff and			ursing and unit managers,	
		sick leave on 10/03/23 and			quarterly care conferences	
	_	eave that Med Aide #1 was		_	frequency of 5 residents	
	no longer with the fac	ility which she assumed he		5x/week x 12	weeks. Any concerns	
	had been terminated	due to the PIP. The DON		identified thro	ough facility screening will	be
	later found out he was	s transferred to a sister		reported to the	ne Director of Nursing who)
	facility. The HCPI cor	ntinued to report that Unit		will complete	an evaluation of the resid	lent
	Manager #1 informed	her that one day, she did		and documer	nt any follow-up required.	
	,	e noticed Resident #1 was		Variances wil	Il be corrected at the time	of
		ad a change in her behavior.		observation a	and additional education	
		the Resident about it, she		'	en indicated. The	
		e didn't say goodbye and			r will continue to be made	
		al but would not elaborate on		1	instances of abuse,	
	what she meant.				behavior, or any other	
					ncern related to citation F6	500
	_	nd observation made with			y the Director of Nursing.	
	Resident #1 on 12/05				rator will audit at minimum	า
		ng on her bed fully dressed			completion of the audits	
		well-groomed explained she		stated above		
	-	are without the assistance of			results will be reported to	the
		nt indicated she had been at			r (from the Director of	
	the facility for about 5	years and had to come to		Nursing) wee	ekly for the next 3 months	

the facility because of her diabetes and had to

beginning on 1/10/24 and concerns will be

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		345303	B. WING			12/	07/2023
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				70	SWEETEN CREEK ROAD		
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F 600	Continued From page have insulin injection displayed no apprehe safe at the facility. Re reason for the visit, ir had had a recent end. The Resident responkeep asking me about who? The Resident responkeep asking me about who? The Resident responkeep asking me about who? The Resident responkeep asking me about asked what was consexplained, "we kissed and he kissed me ba stated, "it wasn't all high just as much as he did as lasting about 3 settongue involved, "just asked how it made he because he must have When asked how he explained that she have worked 7:00 PM to 7 her nighttime medica and talk about her fambecame close, and he Resident #1 reported that she needed a frict there for her. She state brought a smile to he explained that the laste he told her that he have him to work more how the safe to	s. Resident #1 was calm and ension and stated she felt esident #1 inquired about the which she was asked if she counter with a staff member? ded, "why does everybody at him?" When asked about eplied, the name of Med not reported "what we had it did not involve sex". When sensual the Resident don the lips, I kissed him ck, it wasn't all him". She im because she wanted it id". She described the kiss conds and there was no to a kiss on the lips". When er feel she indicated "good, we known that I needed it". knew she needed it, she ad been very worried for ily situation and she stated that the Med Aide 100 AM and when he brought tions to her, they would visit mily problems, that they e would hold her hand. If the Med Aide #1 could see end in her life, and he was steed when she was down, he		600		A y	
	night first by tucking t and moving up the si	he tucked her in bed that the covers up over her legs des of her body then as he					
	raised up to her face	they just kissed on the lips.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '			(X3) DATE SURVEY COMPLETED		
	345303	B. WING _			C 12/07/2023		
	RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803	· · · · · · · · · · · · · · · · · · ·	12/01/2023		
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F 600 Continued From page 4 She stated it only happened one time and it was not planned. The Resident repeated it was		F 6	00				
"consensual". The F happened about 2 n seen him since. She about him, she was back in the facility. S for 3 weeks because The Resident stated through the door rig big hug and ask him Resident stated she	Resident reported that nonths ago and she has not e stated when she asked staff told that he was not allowed She stated she cried over him e she did not get "closure". If Med Aide #1 walked ht now she would give him a where he had been. The had discussed her feelings						
with Nurse #1 she ee Resident #1 on day explain that one day when) Resident #1 or room and relayed to #1's husband had go facility where Med A Resident wrote her paper and asked the number to her husbabecause she "needed pass the number alout The Nurse stated she what she meant by that if the Resident would have told her did not give the Reshusband but threw is stated a few weeks she passed her num told her that she did worked a different si	explained that she worked with shift. She continued to a shift. She continued to a shift. She could not remember called her into the Resident's her that she knew Nurse one to work at the other ide #1 transferred to. The othone number on a piece of a Nurse if she would give the eand to give to Med Aide #1 and to give to Med Aide #1 and the did not ask the Resident closure" because she felt wanted her to know then she Nurse #1 reported that she ident's number to her a taway instead. The Nurse later Resident #1 asked her if the other to Med Aide #1 and she in't because her husband thift and did not see the Med						
-	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From page She stated it only ha not planned. The Re "consensual". The Re happened about 2 n seen him since. She about him, she was back in the facility. S for 3 weeks because The Resident stated through the door rigl big hug and ask him Resident stated she with the Administrate On 12/05/23 at 12:0 with Nurse #1 she e Resident #1 on day explain that one day when) Resident #1 or oom and relayed to #1's husband had ge facility where Med A Resident wrote her p paper and asked the number to her husba because she "neede pass the number alc The Nurse stated sh what she meant by ' that if the Resident to would have told her. did not give the Res husband but threw it stated a few weeks she passed her num told her that she did worked a different si Aide. The Nurse rep	RELS OF GREENTREE RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4	ROVIDER OR SUPPLIER RELS OF GREENTREE RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 She stated it only happened one time and it was not planned. The Resident repeated it was "consensual". The Resident repeated it was "consensual". The Resident repeated hat happened about 2 months ago and she has not seen him since. She stated when she asked staff about him, she was told that he was not allowed back in the facility. She stated she cried over him for 3 weeks because she did not get "closure". The Resident stated if Med Aide #1 walked through the door right now she would give him a big hug and ask him where he had been. The Resident stated she had discussed her feelings with the Administrator and Nurse #1. On 12/05/23 at 12:00 PM during a conversation with Nurse #1 she explained that she worked with Resident #1 on day shift. She continued to explain that one day (she could not remember when) Resident #1 called her into the Resident's room and relayed to her that she knew Nurse #1's husband had gone to work at the other facility where Med Aide #1 transferred to. The Resident wrote her phone number on a piece of paper and asked the Nurse if she would give the number to her husband to give to Med Aide #1 because she "needed closure" and if she did not pass the number along then she understood. The Nurse stated she did not ask the Resident what she meant by "closure" because she felt that if the Resident wanted her to know then she would have told her. Nurse #1 reported that she did not give the Resident's number to her husband but threw it away instead. The Nurse stated a few weeks later Resident #1 asked her if she passed her number to Med Aide #1 and she told her that she didn't because her husband worked a different shift and did not see the Med Aide. The Nurse reported she never informed the	RELS OF GREENTREE RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY SPULL REGULATORY ON LSC IDENTIFYING INFORMATION) Continued From page 4 She stated it only happened one time and it was not planned. The Resident repeated it was "consensual". The Resident repeated it was not planned. The Resident when she was told that happened about 2 months ago and she has not seen him since. She stated when she asked staff about him, she was told that he was not allowed back in the facility. She stated she cried over him for 3 weeks because she did not get "closure". The Resident stated if Med Aide #1 walked through the door right now she would give him a big hug and ask him where he had been. 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The Resident stated if Med Aide #1 walked through the door right now she would give him a big hug and ask him where he had been. The Resident of the appened above the stated she did not get "closure". The Resident of the appened above the stated she was not planned that she worked with Nurse #1 she explained that she worked with Resident #1 on day shift. She continued to explain that one day (she could not remember when) Resident for he had been the facility where Med Aide #1 transferred to. The Resident work at the other facility where Med Aide #1 transferred to. The Resident work at the other facility where Med Aide #1 transferred to. The Resident work at the other facility where Med Aide #1 transferred to. The Resident was the meant by "closure" because she felt that if the Resident wanted her to know then she would have told her. Nurse #1 reported that she did not give the Resident wanted her to know then she would have told her. Nurse #1 reported that she did not give the Resident wanted her to know then she would have told her number to Med Aide #1 transferred to the head of the Populary of the Aide #1 transferred to the head		

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request. During an interview 12/06/23 at 7:50 AM day (he could not revisit Resident #1 at to work at the facilit Resident #1 told hir worked with Med Ai statement "nothing kissed". The NA state aback and he did not comment, but he reon duty at the time. that sometime later to give her phone into Med Aide #1, but phone number away Med Aide #1. A follow up interview 11:10 AM revealed #1 telling her that R the Resident and M nothing happened be stated had she been have reported it to to to the other side of Manager #2. UM #1 the conversation be #2 was about, but ke	with Nurse Aide (NA) #1 on and the NA explained that one emember when) he went to the facility because he used by. The NA reported that in that she knew that he de #1 and made the chappened between us, we just ted her comment took him to task her to elaborate on the ported it to Nurse #1 who was the NA continued to explain Resident #1 asked Nurse #1 umber to NA #1 to pass along they threw the Resident's and did not pass it along to with Nurse #1 on 12/06/23 at that she did not remember NA esident #1 had reported that ed Aide #1 kissed, and between them. The Nurse in notified of that; she would he Administrator. 5 PM during a conversation UM) #1, she reported that one call the exact date, she noticed alked by her office and did not normally did but instead went the facility to speak with Unit stated she did not know what the Resident #1 and UM new it was upsetting to	F 600		
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From parrequest. During an interview 12/06/23 at 7:50 AM day (he could not revisit Resident #1 at to work at the facilit Resident #1 told hir worked with Med Ai statement "nothing kissed". The NA sta aback and he did no comment, but he re on duty at the time. that sometime later to give her phone no to Med Aide #1, but phone number away Med Aide #1. A follow up interview 11:10 AM revealed #1 telling her that R the Resident and M nothing happened be stated had she been have reported it to to On 12/05/23 at 1:55 with Unit Manager (day, she did not red Resident #1 had wa stop to talk as she r to the other side of Manager #2. UM #1 the conversation be #2 was about, but k Resident #1. UM #1	RELS OF GREENTREE RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 request. During an interview with Nurse Aide (NA) #1 on 12/06/23 at 7:50 AM the NA explained that one day (he could not remember when) he went to visit Resident #1 at the facility because he used to work at the facility. The NA reported that Resident #1 told him that she knew that he worked with Med Aide #1 and made the statement "nothing happened between us, we just kissed". The NA stated her comment took him aback and he did not ask her to elaborate on the comment, but he reported it to Nurse #1 who was on duty at the time. The NA continued to explain that sometime later Resident #1 asked Nurse #1 to give her phone number to NA #1 to pass along to Med Aide #1, but they threw the Resident's phone number away and did not pass it along to	ROVIDER OR SUPPLIER RELS OF GREENTREE RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 request. During an interview with Nurse Aide (NA) #1 on 12/06/23 at 7:50 AM the NA explained that one day (he could not remember when) he went to visit Resident #1 at the facility. The NA reported that Resident #1 told him that she knew that he worked with Med Aide #1 and made the statement "nothing happened between us, we just kissed". The NA stated her comment took him aback and he did not ask her to elaborate on the comment, but he reported it to Nurse #1 who was on duty at the time. The NA continued to explain that sometime later Resident #1 asked Nurse #1 to give her phone number to NA #1 to pass along to Med Aide #1, but they threw the Resident's phone number away and did not pass it along to Med Aide #1. A follow up interview with Nurse #1 on 12/06/23 at 11:10 AM revealed that she did not remember NA #1 telling her that Resident #1 had reported that the Resident and Med Aide #1 kissed, and nothing happened between them. The Nurse stated had she been notified of that; she would have reported it to the Administrator. On 12/05/23 at 1:55 PM during a conversation with Unit Manager (UM) #1, she reported that one day, she did not recall the exact date, she noticed Resident #1 had walked by her office and did not stop to talk as she normally did but instead went to the other side of the facility to speak with Unit Manager #2. UM #1 stated she did not know what the conversation between Resident #1 and UM #2 was about, but knew it was upsetting to Resident #1. UM #1 continued to explain that	RELS OF GREENTREE RIDGE SUMMARY STATEMENT OF DEFICIENCIES (RECH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) COntinued From page 5 request. During an interview with Nurse Aide (NA) #1 on 12/06/23 at 7:50 AM the NA explained that one day (who could not remember when) he went to visit Resident #1 at the facility. The Air ported that Resident #1 told him that she knew that he worked with Med Aide #1 and made the statement "nothing happened between us, we just kissed". The NA stated her comment, but he reported it to Nurse #1 to give her phone number to NA #1 to pass along to Med Aide #1, but they threw the Resident's phone number away and did not pass it along to Med Aide #1. A follow up interview with Nurse #1 on 12/06/23 at 11:10 AM revealed that she did not as the number NA #1 tilling her that Resident #1 had reported that the Resident and Med Aide #1 kitsed, and nothing happened between them. The Nurse stated had she been notified of that; she would have reported it to the Administrator. 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	DGE		STREET ADDRESS, CITY, STATE, ZIP CODE 70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803	'	12/01/2020
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nd was team It to her fam Resident # at she was 'apologize" Resident whated, "he jution". The F it was consensual. by the commonsensual e Resident on. The UM state it was gether and it ng to becau ide #1 left t the Adminis on via telepl not rememb it no longer it the situation w was cond at 2:35 Pi out a month ook on her it something her office. V	ful which the UM thought ily dynamics. The UM went 1 and the Resident upset because someone to her but when the UM hat she was referring to the lest left and didn't give her Resident made the ensual" but would not say. The UM stated she was ment and when she asked and who she was referring would not continue the explained that although is Med Aide #1, she put two felt it was the Med Aide she se it was right around the he facility. UM #1 stated trator aware of the none that day or the next, er which. The UM reported reworked at the facility, so on was handled. Jucted with Unit Manager #2 M. The UM explained that he or so ago Resident #1 is building and the UM could face that the Resident was g, so she asked her to when they went into the	F 60	· · ·		
	From page and was tear to her fam Resident # at she was "apologize" Resident what ted, "he jution". The Fit was consensual by the componsensual are Resident what te the Administration of the Administration of the Son via telephot remember the situation of the situation was conditionally was conditionally was conditionally the situation of the s	JPPLIER SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION) From page 6 and was tearful which the UM thought do to her family dynamics. The UM went Resident #1 and the Resident at she was upset because someone "apologize" to her but when the UM Resident what she was referring to the tated, "he just left and didn't give her tition". The Resident made the it was consensual" but would not say consensual. The UM stated she was by the comment and when she asked consensual and who she was referring the Resident would not continue the form. The UM explained that although it state it was Med Aide #1, she put two gether and felt it was the Med Aide she and to because it was right around the wide #1 left the facility. UM #1 stated the Administrator aware of the continuation of the continuation of the interest of the continuation of the situation was handled. We was conducted with Unit Manager #2 at 2:35 PM. The UM explained that bout a month or so ago Resident #1 for side of the building and the UM could book on her face that the Resident was it something, so she asked her to the office. When they went into the	JPPLIER SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION) From page 6 Ind was tearful which the UM thought do to her family dynamics. The UM went Resident #1 and the Resident at at she was upset because someone "apologize" to her but when the UM Resident what she was referring to the tated, "he just left and didn't give her tion". The Resident made the it was consensual" but would not say consensual. The UM stated she was by the comment and when she asked consensual and who she was referring her Resident would not continue the on. The UM explained that although at state it was Med Aide #1, she put two gether and felt it was the Med Aide she and to because it was right around the indice #1 left the facility. UM #1 stated the Administrator aware of the on via telephone that day or the next, not remember which. The UM reported #1 no longer worked at the facility, so at the situation was handled. W was conducted with Unit Manager #2 3 at 2:35 PM. The UM explained that sout a month or so ago Resident #1 er side of the building and the UM could cook on her face that the Resident was at something, so she asked her to the office. When they went into the	JEPPLIER 345303 JEPPLIER 345303 STREET ADDRESS, CITY, STATE, ZIP CODE 70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803 SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL LIATORY OR LSC IDENTIFYING INFORMATION) From page 6 Ind was tearful which the UM thought do to her family dynamics. The UM went Resident #1 and the Resident at she was upset because someone "apologize" to her but when the UM Resident what she was referring to the lated, "he just left and didn't give her titom". The Resident made the it was consensual. The UM stated she was by the comment and when she asked consensual and who she was referring the Resident would not continue the on. The UM explained that although state it was Med Aide #1, she put two gether and felt it was the Med Aide she ng to because it was right around the didned #1 left the facility. UM #1 stated the Administrator aware of the on via telephone that day or the next, not remember which. The UM reported #1 no longer worked at the facility, so it the situation was handled. W was conducted with Unit Manager #2 3 at 2:35 PM. The UM explained that had out a month or so ago Resident #1 er side of the building and the UM could ook on her face that the Resident was it something, so she asked her to	JPPLIER 345303 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803 SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LISC IDENTIFYING INFORMATION) From page 6 Ind was tearful which the UM thought It to her family dynamics. The UM went Resident #1 and the Resident at she was upset because someone "apologize" to her but when the UM Resident what she was referring to the tated, "he just left and didn't give her tit was consensual The UM stated she was by the comment and when she asked consensual and who she was referring the Resident would not continue the form. The UM explained that although state it was Med Aide #1, she put two gether and felt it was the Med Aide she ring to because it was right around the ide #1 left the facility, UM #1 stated the Administrator aware of the on via telephone that day or the next, not remember which. The UM reported that no longer worked at the facility, so if the situation was handled. W was conducted with Unit Manager #2 3 at 2:35 PM. The UM explained that out a month or so ago Resident #1 or side of the building and the UM could dook on her face that the Resident was it something, so she asked her to her office. When they went into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	and would keep in comot seen the Med Aidexplained that she as was something she in and the Resident stated together that was not elaborate on what the stated the Resident's concerning to her that Administrator and information betwee UM stated she asked needed to write a state conversation and the hold off until they cout to happen. During an interview with 12/05/23 at 3:05 PM work at the facility in discovered Med Aide facility. The NA explaineded to inform the that there had been in that Med Aide #1 was third shift, so she reputation was hard to remembout of his mind (would hard to put out of his often he took care of stated that he would	would be gone for a while ontact with her, but she had de since he left. UM #2 sked the Resident if there needed from Med Aide #1 ted no, they had moments a sexual and would not be "moments" were. The UM is statements were so not she went straight to the formed her of the in her and the Resident. The is the Administrator if she tement about the standard and the UM to all figure out what was going with Nurse Aide #2 on the NA stated she went to early June 2023, and she will also worked at the sined that she felt like she Director of Nursing (DON) tumors at the other facility is intimate with a resident on	F 60		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 600	replied, "absolutely n thinking of". He state her, not once, are yo building". The Med A remember her now, s lady and we have tal kissed her. We talked because I haven't sp When the Med Aide that he and Resident what would he say to stated, "it would be a kissed her in the more even on the forehead know myself pretty w not do that". The Mehad joked around a le Med Aide was asked	dent #1 the Med Aide ot, not if she is the one, I am d, "I have not ever kissed u kidding with COVID in the ide continued to report "I she gets insulin, very sweet ked but no, I have never d about nothing significant ent a lot of time with her". was asked if it was reported #1 had kissed in the mouth, that and the Med Aide lie because I have never uth or anywhere else, not I". Med Aide #1 stated "I ell and I know that I would d Aide explained that they of but that was it. When the if he ever referred to	F 60	0		
	replied "No, I have a was asked if an inappletween a resident a should it be reported it was unwanted and ma'am" but I never swhen I was around, a be glad to see me'. V Resident was in her good decisions the Minteracted with her erassumption. The Mespoke to Resident #1 A review of Resident progress notes dated revealed that Reside coherent and seemes	and a staff member occurred, and the Med Aide stated, "if bothered her then yes eemed to bother Resident #1 and she seemed to always When asked if he thought the right mind and could make led Aide replied he never hough to make that d Aide denied that he ever about leaving the facility.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER THE LAURELS OF GREENTREE RIDGE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 9 the Resident, and the Psychotherapist positively reinforced the use of reframing to reduce the Resident's distress. An interview was conducted with the Psychotherapist on 12/06/23 at 12:00 PM. The Psychotherapist explained that the personal issues that were discussed between she and Resident #1 were the Resident's personal feelings that she felt for someone, and the Resident felt that the someone had those feelings for her as well, but then he left. The Resident explained that she and the staff member would spend time with her, having kind things to say to her. She liked him and was happy to have him but was struggling with her feelings because she was married. She said he had another part-time job and he left but she did not say if he left because of what they had (between them) or if he had to leave (for another reason). The Resident		STREET ADDRESS, CITY, STATE, ZIP CODE 70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803						
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
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	the Resident, and the reinforced the use of	e Psychotherapist positively						
	Psychotherapist on Psychotherapist expissues that were discressives that were discressives that she felt Resident felt that the for her as well, but the explained that she as spend time with her, her. She liked him a but was struggling was married. She sa job and he left but she because of what the had to leave (for and was sad that he left goodbye. The Psychot know anything a staff member kissing and was consensual the part of the staff root find Resident #1 in general she seem judgement. She stat loved the time they wasn't upset that she staff member and we enjoyed having him Psychotherapist staft that she had already someone, so she the of it. The Psychothe staff member was	12/06/23 at 12:00 PM. The lained that the personal cussed between she and e Resident's personal for someone, and the someone had those feelings hen he left. The Resident and the staff member would having kind things to say to have him with her feelings because she had another part-time he did not say if he left y had (between them) or if he						

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F 600	sad and had her fee she had with her; the Psychotherapist represented the Psychotherapist representation of the Psychotherapist representa	is it with the facility. She was lings hurt but the next visit at Resident was over it. The corted that she thought ood her situation with the the kiss happened the her consent to the kiss. with the Supervisor on and, the Supervisor stated that the weekend Supervisor since the ervisor explained that he had be acility as well. He continued the heleft the previous facility, facility investigating the Med were reports of him having the abuse toward a resident. The did not know the stigation because he left ion was complete. The did to explain that he had heard and Resident #1 interesting the Left ion was complete. The did not know the stigation because he left interesting the Med were reports of him having the help the did not know the stigation because he left into was complete. The did to explain that he had heard and Resident #1 interesting the Med what he knew about the ther facility to the DON and for of Nursing which he did.	F	DEFICIENCY)			
	An interview was coon 12/06/23 at 3:35 worked as a treatmed ay she was talking Resident remarked they were really	e she was out of the country. Inducted with Nurse Aide #3 PM who explained that she ent aide at the facility and one with Resident #1 when the chat she missed Med Aide #1, close. She stated she could he left and wasn't reaching					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SUI COMPLET		
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F 600	it being "consensual" what she meant by consensual who	ated Resident #1 mentioned but did not elaborate on onsensual. The NA stated conversation to the ethe Resident did not hip was inappropriate. AM during an interview with not (PA), he reported he did a very well because he had the facility since early A explained that he had only few times but his day-to-day has she was alert and the insight into her medical used to explain that Resident stand what was going on the fout had underlying anxiety insight in judgement was understanding in the led if there was known dialog and Med Aide #1, she could be easily manipulated. The medical stand what was going on the led if there was known dialog and Med Aide #1, she could be the assumed that if she led if Resident #1 could give the PA stated she was alert no in the moment, but her be appropriate.	F	500	CIENCITY		
	DON continued to ex middle of a disciplinal	ors toward the residents. The plain that she was in the ry process with the Med Aide and had to be out of work.					

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		345303	B. WING				07/2023
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F 600	that he was transfe DON reported that a conversation, but about the rumors gu #1 and Med Aide # DON that the Reside where she fabricate herself, and a previ Administrator told the Resident #1 about Resident told the Administrator told the Resident would be back to w DON it was the san with a previous phybecause apparently that she was in a resident was done about it be kiss like it was a go She stated she did was done about it be the Abuse Coordinating interviews where the that Med Aide was a Medication Aid transferred to a sist and ADON informed that Med Aide #1 has some sort of allegar where he was emplistated she advised	she heard from a coworker rred to a sister facility. The she and the Administrator had could not remember when, bing around between Resident 1. The Administrator told the lent had a situation in the past ed a relationship between ous physician and the lith it was the same thing. The ne DON that she had asked the Med Aide, and the dministrator that the Med Aide at night and giving her kisses as asking when the Med Aide ork. The Administrator told the ne situation that happened sician a few years earlier a Resident #1 had fabricated elationship with a physician. The Administrator described the od night kiss on the forehead. The Administrator what because the Administrator was ator, and she was under the	F	600			

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	· ·	and told him that they had		•			
		nors. The Med Aide then					
	1	rator about transferring to a					
		e Administrator was in					
		s able to provide the Med Aide					
	_	to the other facility. The					
		nued to explain that it was					
		Med Aide had transferred to					
		t Unit Manager #2 informed					
	her that Resident #						
	dating Med Aide #1						
	she went to talk witl						
	Resident was crying						
		pecause someone had left					
	_	inistrator asked her to explain					
	the Resident refuse	ed to talk about it, so she left					
	the Resident alone.	The Administrator stated she					
	asked Unit Manage	r #1 to go talk with Resident					
	#1, but the conversa	ation did not go any further					
	with Unit Manager #	#1. The Administrator					
	explained that on th	ne following Monday she went					
		sident #1 and this time the					
		o and told her that she was					
		se she was dealing with family					
		le #1 would come into her					
	_	ould sit and listen to her so					
	_	ne point where she relied on					
		a shoulder to cry on. The					
		that the last night the Med					
		her that he would see her in					
	1	nd he never came back. The					
		e was sad and angry so when					
		talking about Med Aide #1					
	_	Resident thought it was with					
	_	he Administrator stated that					
		she understood why the Med					
		ve but was mad that he did not					
		g the second conversation					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 607 SS=D	tuck her in at night, ki would tell the Resider Administrator stated to the Resident reported her on the forehead be on any kind of male at a kiss on the forehead depended on the circular all kiss residents on the take care of the resident and if they were okay then she thought a king minimal way to do so not. The Administrato kiss on the forehead Resident #1 and Med what she knows now, groom the Resident at Develop/Implement ACFR(s): 483.12(b)(1)-\$483.12(b)(1) Prohibit implement written policy 483.12(b)(2) Establit to investigate any successions.	trouble because he would ss her on the forehead and at that he loved her. The that it gave her pause when a that Med Aide #1 kissed because the Resident fixated attention. She explained that debeing acceptable cumstances. She stated we the forehead because we tents and get close to them at to hug or show affection as on the forehead was a but a kiss in the mouth was ar stated she did not think a was appropriate between a Aide #1 because knowing the Med Aide seemed to and it was not acceptable. The should be and icies and procedures that: It and prevent abuse, ion of residents and esident property, It also procedures that: It and prevent abuse, ion of residents and esident property, It also procedures that: It and prevent abuse, ion of residents and esident property, It also procedures that: It and prevent abuse, ion of residents and esident property, It also procedures that: It and prevent abuse, ion of residents and esident property, It also procedures that: It and prevent abuse, ion of residents and esident property, It also procedures that: It and prevent abuse, ion of residents and esident property, It also procedures that: It and prevent abuse, ion of residents and esident property, It also procedures that: It and prevent abuse, ion of residents and esident property, It also procedures that the procedu		607			1/3/24

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F 607	facilities in accordance Act. The policies and but are not limited to §483.12(b)(5)(ii) Pose employee rights, as of (3) of the Act. §483.12(b)(5)(iii) Pro- retaliation, as defined (2) of the Act. This REQUIREMENT by: Based on facility reco- interviews the facility abuse policy and pro- investigation when the previous employee (Notes in the previous employee) investigated for inapp with a resident at a single residents reviewed for The findings include: The facility policy title with a revised date of resident shall be free mistreatment, exploits of property. Abuse showerbal, mental, sexual punishment, and involves residents are free from monitor residents car on-going basis. It is to provide a safe environer.	e reporting of crimes funded long-term care the with section 1150B of the diprocedures must include the following elements. Iting a conspicuous notice of defined at section 1150B(d) Inhibiting and preventing dipart at section 1150B(d)(1) and It is not met as evidenced For a review and staff failed to implement their cedure in the area of de facility became aware of a Med Aide #1) being propriate sexual behavior ster facility for 1 of 3 ar abuse (Resident #1). In a language of the facility shall and the facility shall and treatments on an and responsibility of all staff to anomet for the residents. At abuse shall be thoroughly	F 60	F607: The facility will continue to ensur abuse policy in the area of invest implemented. Resident #1 has had no identificate negative outcomes because of the allegation and continues to be seroutinely for psychiatric/psycholoservices. Medication Aide #1 no longer work facility. Current vulnerable residents have potential to be affected. From 12/6/23-12/9/23 the nursing admitteam conducted interviews with residents that have a BIMs of 13 greater (cognitively intact) to det they felt safe in the facility. There issues identified. No residents reinappropriate sexual advances by Aide #1 or any other staff membors. Between 12/25/23-12/29/23 the nurse conducted skin assessme of the residents that had BIMS or	etigation is ed his een ogical orks at the ve the hinistration all or ermine if e were no eported by Med er. treatment nts on all	

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THE LAUF	RELS OF GREENTREE I	RIDGE		ASHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Continued From page Administrator. On 12/04/23 at 9:55 conducted with the Finvestigator (HCPI) of facility on 11/15/23 to Medication Aide (Mestaff in relation to a consister facility. She exthe Administrator, Di Unit Manager (UM) from the Finappropriate relation and Resident #1. The that the Administrator transferred to the sist gotten close to a resulistener because she family dynamics and circulating about him gotten a fair shake. That Unit Manager #1 she did not know the #1 was sad and tear behavior. When she about it, she would conduct goodbye and that it we laborate on what she resident #1 was administration of the world conduction.	AM an interview was dealth Care Personnel who reported she went to the preview the personnel files of did Aide) #1 and interview the current investigation at a splained that she interviewed rector of Nursing (DON), and #1 at the facility and from the ere could have been an aship between Med Aide #1 ere HCPI continued to explain a reported Med Aide #1 was ster facility because he had ident by being an active was going through some there were rumors a with the staff and he had not the HCPI continued to report a informed her that one day, a day, she noticed Resident ful and had a change in her spoke with the Resident sonly say that he didn't say was consensual but would not the meant.		than 13 to determine if there were signs of abuse. No issues were id On 12/29/23 the Reginal Clinical Coordinator re-educated the facili Administrator and the Assistant D Nursing on the abuse policy and procedure. The education empharesident sright to be free from al Definitions and types of abuse, prof abuse, identification of abuse, a protecting residents from abuse wereviewed as well as reporting exafrom the state operations manual. On 12/29/23 the Reginal Clinical Coordinator re-educated the facili Administrator and the Assistant D Nursing on the process for transferactive employee from one facility another. The education emphasiz process for communicating allegate abuse from one facility to another expanding investigations as approximated to a superior the Administrator, Assistant Direct Nursing on the abuse policy and procedure. The education empharesident resident to be free from all Definitions and types of abuse, prof abuse, identification of abuse, a protecting residents from abuse wereviewed as well as reporting exafrom the state operations manual.	any entified. ty irector of sized a puse. evention and rere entified and printer of erring and to ed the tions of and printe. ced by tor of sized a puse. evention and rere evention and rere emples. The	
	The quarterly Minimu assessment dated 0 Resident #1 was cog	8/18/23 revealed that		education began on 12/29/23 with education to be completed by 1/2. Newly hired employees after 1/2/2 receive mandatory in person education.	/24. 24 will	
		nducted with Resident #1 on M. The Resident reported that 1 had a "consensual		the Assistant Director of Nursing of general orientation prior to the state their first shift. The education will	during	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		TE SURVEY MPLETED	
			7 50.25				С	
		345303	B. WING _			1	2/07/2023	
NAME OF P	ROVIDER OR SUPPLIER		'	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				70	SWEETEN CREEK ROAD			
THE LAURELS OF GREENTREE RIDGE (Y4) ID SLIMMARY STATEMENT OF DEFICIENCIES			Α	SHEVILLE, NC 28803				
(X4) ID	(**)			PROVIDER'S PLAN OF CORRECTION	I	(X5)		
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE	
F 607	Continued From p	age 17	F	607				
		id not involve sex, it was a kiss			empathize a resident⊡s right to be fre	е		
		Resident described the Med			from abuse. Definitions and types of			
	_	d would hold her hand and			abuse, prevention of abuse, identifica			
		her when she needed a friend			of abuse, and protecting residents fro			
		ily problems with. Resident #1			abuse were reviewed as well as repor	ting		
		was sad when the Med Aide			examples from the state operations			
		adness turned to anger when he			manual.			
		after a few weeks before she			A QA monitoring tool will be utilized to			
	was told that Med Aide #1 could not come back				ensure ongoing compliance by the			
	the facility.			ng				
	Duning a sur intermita	www.th. Newson Aido #20 am			on 1/3/24. The Regional Clinical			
	_	w with Nurse Aide #2 on			Coordinator will review all transfer pad	ckeis		
		M the NA stated she went to			weekly x 12 weeks to ensure that the			
		in early June 2023, and ide #1 also worked at the			employee transfer process is being	f		
		plained that she felt like she			followed and that any/all allegations o abuse involving transferred employee			
		he Director of Nursing (DON)			are communicated from one facility to			
		n rumors at the other facility			another with expanded investigations			
		was intimate with a resident on			conducted as appropriate. Variances	will		
		reported it to the DON.			be corrected at the time of review and			
	lam d'orma, do orio i	operiod it to the Bern			additional education provided when			
	During an interviev	w with the Supervisor on			indicated. All findings will be documer	nted		
		M, the Supervisor stated he			on QA monitoring tool by the Regiona			
		e facility in June 2023 and			Clinical Coordinator. The Administrator			
		had worked with Med Aide #1 at			audit this tool at a minimum of monthl			
	l •	and was surprised to see that			Observation results will be reported to	•		
		ked at this facility as well. The			Administrator (from the Regional Clini	linical months s will be		
	Supervisor continu	ued to explain that he was			Coordinator) weekly for the next 3 mo			
	aware of Med Aide	e #1 being investigated at			beginning on 1/10/24 and concerns w			
	another facility for	sexual misconduct or abuse of			reported to the QA committee during			
	a resident. The Su	pervisor stated that he had			monthly meetings.			
		ut the Med Aide and Resident			Continued compliance will be monitor			
		propriate relationship and			through the facility□s Quality Assuran	ce		
		report what he knew about the			Program.			
		other facility to the DON and			Compliance will be monitored by the 0	QΑ		
	the Assistant Direct	ctor of Nursing which he did.			Committee for 3 months during the			
					January through March regularly			
		conducted with the Director of			scheduled meetings or until resolved	and		
	Nursing (DON) on	12/05/23 at 4:00 PM. The DON			additional education/training will be			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345303	B. WING _				07/ 2023
NAME OF PI	ROVIDER OR SUPPLIER	l	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	0172020
			70 SWEETEN CREEK ROAD		0 SWEETEN CREEK ROAD		
THE LAURELS OF GREENTREE RIDGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			Α	SHEVILLE, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	CEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
F 607	Continued From page	e 18	F	307			
	explained that she wadisciplinary process we became ill and had to she could not personate While she was out, she that the Med Aide was facility. The DON report Administrator had a common going around Med Aide #1. The Administrator had a common going around Med Aide #1. The Administrator had a common going around Med Aide #1. The Administrator had a common going around Med Aide #1. The Administrator had asked Resident told Med Aide was tucking her kisses and the Resident had a kide would be becaused in the Resident had a kide would be becaused in the Resident had a kide would be becaused in the Resident had a kide would be becaused in the Resident had a kide would be becaused in the Resident had a kide would be becaused in the Resident had a kide would be becaused in the Resident had a kide would be becaused in the Resident had a kide would be becaused in the Resident had a kide was th	as in the middle of a with Med Aide #1 when she be out of work therefore, ally complete the process. he heard from a coworker is transferred to a sister orted that she and the conversation about the between Resident #1 and ministrator told the DON that ent #1 about the Med Aide, the Administrator that the g her in at night and giving esident was asking when the ack to work. The DON tor described the kiss like it			provided for any issues identified. Date of compliance 1/3/24.		
	interviews were cond The Administrator exy was transferred to a s was informed that the Med Aide had been a sort of allegation from was employed, and th around this facility. SI Aide #1 was transferr from staff about conc Resident #1 had mad interview Resident #1 reported she was sad left her, but the Resid she meant until she v a different day. The A on the second visit, R when she would be u Med Aide #1 would go	PM and 12/07/23 at 4:15 PM ucted with the Administrator. Dained that Med Aide #1 sister facility because she are were rumors that the rrested because of some in a different facility where he are rumors were going the stated it was after Med and that she received reports erning comments that the end and the Resident to twice and the Resident to twice and the Resident again on administrator explained that the Resident #1 reported that pset about her family issues, to into her room at night and and listen to her, so she got					

CENTERS FOR WEDICARE & W	IEDICAID SERVICES				CIVID IVC	7. 0930 - 0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONST	(X3) DATE SURVEY COMPLETED		
	345303	B. WING _				07/ 2023
NAME OF PROVIDER OR SUPPLIER		•	STREET	ADDRESS, CITY, STATE, ZIP CODE		****
TO WILL OF THOUBER OR GOT FELEN				, , ,		
THE LAURELS OF GREENTREE RIG	DGE			ETEN CREEK ROAD		
			ASHEV	ILLE, NC 28803		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
be there for a shoulder reported that the Med A her in a few days, and that made her sad and goodbye to her. The Ad Resident #1 continued not want to get the Med when he would tuck he would kiss her on the fine loved her. The Admikiss on the forehead we affection toward the rest The Administrator explout that Med Aide #1 we their sister facility for in a resident it should have Resident #1 again, but interview would stay the had opened up an investigation include interview than Resident #1. She conference call with the was known their sister citation related to Med behavior with a resider any direction to reinvestigation to reinvestigation.	relied on the Med Aide to to cry on. The Resident Aide told her he would see he had not been back and angry since he did not say dministrator stated that to inform her that she did d Aide into trouble because er into bed at night, he orehead and tell her that inistrator explained that a as a minimal way to show sidents if they allowed it. ained that when she found was being investigated at appropriate behaviors with we sparked her to interview a she felt that the Resident's are same. She stated if she estigation then she would ity's abuse policy that wing more residents other stated they had a see corporate staff after it facility received a jeopardy Aide #1's inappropriate at and she was not given stigate the situation ledication Aide. She stated ware of Resident #1 er #1 had kissed her in the	F6	607			