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	345221	A. BUILDING _____ B. WING _____	C 06/12/2024

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 06/09/24 through 06/12/24. The faciltiy was found in complaince with the requirement CFR 483.73, Emergency Preparedness. Event ID# OOIV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/06/24 through 06/12/24. The following intakes were investigated: NC00217768, NC00217943, NC00217964, NC00217365, NC00215787, NC00215714, NC00212941, NC00212843, and NC00212941. 1 of 9 allegations resulted in a citation. Event ID#OOIV11.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon	F 644		7/1/24

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

Electronically Signed | 06/28/2024

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F 644	Continued From page 1 a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) Level II was completed for 2 of 2 residents (Resident #80 and Resident #86) reviewed for PASRR. The findings included: 1. Resident #80 was originally admitted to the facility on 12/1/22 and was re-admitted on 5/31/23. A review of Resident #80's medical record indicated bipolar disorder was added to her diagnoses list effective 6/5/23. There was no information in Resident #80's medical record regarding PASRR. An interview with the Social Services Director (SSD) on 6/12/24 at 9:13 AM revealed she started working at the facility in November 2023, and she was responsible for PASRR. The SSD stated she knew Resident #80 had been at the facility for a while even before she started working at the facility. During the interview, the SSD searched for PASRR information in Resident #80's medical record and agreed that she could not find any. She looked up Resident #80's PASRR from the North Carolina Medicaid Uniform Screening Tool website and found a PASRR Level I Determination Notification letter dated 11/30/22. The SSD stated the application for PASRR was submitted on 11/30/22 with dementia as the primary diagnosis and with no mental disorder. She further stated that there was an issue with the psychiatric provider letting her	F 644	Criteria 1 On 6/12/24, residents 80 and 86 were reviewed by the Director of Social Services and level II screening requests were completed for each resident, Criteria 2 All residents with a diagnosis for serious mental illness have the potential to be affected by the deficient practice. The Director of Social Services will complete an audit of all resident diagnoses to ensure that any resident with an existing or new diagnosis for mental illness will have a PASRR level II screening request made on or before 6/30/24. Criteria 3 On 06/27/24, the facility administrator educated team members who participate in the PASRR request process for mental health diagnoses: social services director, minimum data set coordinators, and director of nursing. The education advised on the necessity for timely notification to facility social services director of mental health diagnoses and required requests for PASRR reviews upon admission, readmission, or if a new diagnosis is given. Newly hired team members who will participate in the PASRR review process will be educated on this process by the administrator or social service director upon hire. Criteria 4	

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F 644	Continued From page 2 know about mental diagnoses, and that she would have submitted an application for PASRR Level II if she had known about Resident #80's diagnosis of bipolar disorder. The SSD added that she recently asked the psychiatric provider to let her know of any new mental health disorders. She further shared that there had been a breakdown in communication, and as she continued in her current position, she had been finding things that should have been done by the previous Social Worker. An interview with the Minimum Data Set (MDS) Coordinator on 6/12/24 at 10:41 AM revealed Resident #80 had been diagnosed with bipolar disorder by the psychiatric provider on 6/5/23. The MDS Coordinator stated that the psychiatric provider was supposed to communicate with the Social Worker, and the Social Worker was supposed to apply for a PASRR Level II for the new mental health disorder diagnosis. An interview with the Administrator on 6/12/24 at 2:24 PM revealed he could not speak as to why the PASRR Level II was missed for Resident #80, but that they were now doing a full audit of all residents. The Administrator stated that this was another system that they needed to work on. 2. Resident #86 was readmitted to the facility on 3/25/24 with the diagnosis of anxiety disorder and bipolar disorder. The admission Minimum Data Set (MDS) dated 4/3/24 revealed that Resident #86 was moderately cognitively intact. She was not depressed, and she displayed no behaviors. Resident #86 had a diagnosis of anxiety and bipolar disorder.	F 644	The social services director will audit 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks to ensure requests for PASRR reviews have been submitted based on existing qualifying diagnosis or newly added diagnoses. The facility administrator will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. Date of compliance 7/1/24.	

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F 644	Continued From page 3 On 6/11/24 at 10:06 AM an interview was conducted with the Social Services Director (SSD). The SSD stated she started working at the facility in November 2023. She has been reviewing and going through the Preadmission Screening and Resident Reviews (PASRR) for each resident to ensure they are correct. She printed off the PASRR for Resident #86. The PASRR was dated September 7, 2023. The PASRR stated that no further PASRR screening was required unless a significant change occurs with the resident's status which suggests a diagnosis of mental illness or mental retardation. The SSD stated she has not yet uploaded The PASRR Level I into the Point Click Care (PCC) but would do so today. On 6/12/24 at 11:39 AM a second interview with the SSD was conducted. The SSD stated that the level II PASRR for Resident #86 should have been done back on 9/7/23. She is going through them now and making sure they are correct. On 6/12/24 at 2:44 PM an interview with the Administrator was conducted. He was unable to speak to the PASRRs or what happened, but he did speak to the SW and he knows she will be very diligent in looking into all the PASRRs and ensure they are correct.	F 644		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		7/1/24

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F 692	Continued From page 4 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with resident, staff, Registered Dietitian and the Medical Director, the facility failed to provide a nutritional supplement and double protein as ordered by the Registered Dietitian for 1 of 4 residents (Resident #90) reviewed for nutrition. The findings included: Resident #90 was admitted to the facility on 1/31/24 with the diagnoses of diabetes and a pressure ulcer on left buttocks. On 2/1/24 Resident #90 was weighed using a sit-down scale and his weight was 253.0 pounds. The quarterly Minimum Data Set (MDS) dated 4/23/24 revealed that Resident #90 was alert and cognitively intact. He had no weight loss.	F 692	Criteria 1 On 6/10/24, resident #90's tray card was updated by the dietary manager to reflect the current physician order for double protein and fortified pudding. Criteria 2 All residents in the facility with orders for therapeutic diets for supplemental nutrition have the potential to be affected by the deficient practice. The Registered Dietitian and District Dietary Manager completed an audit of all residents to ensure that the current diet order matched the Meal Tracker System on 6/27/24. This audit included orders for double protein and fortified foods. Areas identified through this audit were immediately corrected. Criteria 3	

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F 692	Continued From page 5 Resident #90's care plan dated 5/15/24 stated he was to have dysphagia (difficulty swallowing) advanced meats and mechanically altered diet for all food categories. The interventions included to provide and serve supplements as ordered and provide and serve diet as ordered. On 4/24/24 Resident #90 was weighed using a total mechanical lift and his weight was 229.4 pounds. 5/28/24 Resident #90 was weighed using a total mechanical lift and he weighed 215.8 pounds. Resident #90 had a physician order stating that Resident #90 was at risk for malnutrition and ordered double protein and fortified pudding with meals starting 6/6/24. On 6/9/24 at 10:33 AM an interview was conducted with Resident #90. Resident #90 stated he did not like to eat bread at his meals and the ground food didn't taste good. Resident #90 stated he had lost some weight. On 6/10/24 at 12:21 PM observation was made of Resident #90's lunch tray and ticket. The tray had chocolate ice cream but no fortified pudding. A single portion of protein was observed on the tray. The lunch ticket did not list fortified pudding or double protein. The resident ate approximately 50 % of his meal. On 6/10/24 at 12:30 PM an interview and observation was conducted with the Registered Dietitian (RD). The RD checked Resident #90's lunch ticket and noticed that it did not have the double portion of protein, nor the fortified pudding listed. The RD stated that she will need to check	F 692	The Administrator provided education to the registered dietician, district dietary manager, and facility dietary manager on 6/27/24. The education included the process for entering new orders into the Meal Tracker system. The registered dietician will ensure that physician orders match tray cards by entering all fortified foods and supplemental nutritional interventions as a preference rather than a supplement so that it appears on the tray ticket. Newly hired staff will be trained prior to working with facility. Criteria 4 The dietary manager will audit all residents weekly for 8 weeks to ensure that the current diet order matches the Meal Tracker System and that the meal ticket reflects the appropriate diet including supplemental nutrition items. The facility administrator will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. Date of compliance 7/1/24.	

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F 692	Continued From page 6	F 692		

the ticket system to see why it was not correct and she will fix it. The RD stated that the fortified pudding and double protein was to increase caloric intake due to weight loss and pressure ulcer.

On 6/10/24 at 3:38 PM an interview was conducted with the Medical Director (MD). The MD stated she just spoke to the RD about Resident #90 last week. The MD stated that some of the weights listed for him were fluid overload. The MD stated that the RD did her own orders. The MD stated Resident #90 had a poor prognosis. The MD was not aware of the fortified pudding or double protein but agreed that if it was ordered he should be receiving it. The MD did not believe there was any negative impact on weight loss and pressure ulcer with the order not starting on 6/6/24.

On 6/11/24 at 2:57 PM an interview was conducted with the Unit Manager who confirmed the order for fortified pudding and double protein for Resident #90. The Unit Manager thought that once she confirmed the order then the RD finished the process to get the order started by sending an email.

On 6/11/24 at 3:30 PM a second interview was conducted with the RD. The RD stated that Resident #90 had poor intake and was barely eating a single portion of the protein and did not feel him missing a double portion would make much difference with his weight loss or on his pressure ulcer.

On 6/11/24 at 4:09 PM an interview was conducted with the Dietary District Manager (DDM) and Dietary Manager (DM). The DDM

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F 692	Continued From page 7 displayed her email chain on the computer. The email chain showed she received an email on 6/3/24 and the next one was on 6/10/24. The DDM stated she never received the 6/6/24 email regarding the diet order and that is why the ticket was incorrect. The DDM stated that the 6/6/24 order did not start when it should have. On 6/12/24 at 11:35 AM an interview was conducted with the DON. She stated the RD did her own orders and the orders are then confirmed usually by the Unit Manager. The facility had a meeting each week called the At-Risk Meeting to go over any resident with weight loss issues. The meeting was usually on Monday. This past Monday the facility did not have the meeting because of the survey going on. If they had the meeting, then they would have caught the diet order change for Resident #90. On 6/12/24 at 2:40 PM an interview with the Administrator was conducted. The Administrator stated that the RD would send out an email when there is a diet order change. The facility would look through the system to make sure dietary orders are not being missed.	F 692		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		7/1/24

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F 812	Continued From page 8 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a clean and sanitary kitchen floor, date an opened nutritional supplement and food in 1 of 3 nourishment rooms (300 hall), clean and sanitize an ice scoop and holder for 1 of 3 ice chests, and date opened cheese in the walk-in refrigerator. This practice had the potential to affect food served to all residents. The findings included: a. An observation of the kitchen on 6/9/24 at 9:44 AM found the kitchen floor tiles to be covered with a black substance and sticky when walked on as evidenced by the sound that was made when the floor was walked on, and the surveyor's shoes stuck to the floor. The black substance and sticky floor were not contained to one area of the kitchen floor and was spread throughout the kitchen. An observation of the kitchen floor on 6/11/24 at 12:18 PM found the kitchen floor unchanged. The floor areas underneath and directly around 3 food prep tables were found to contain food and other debris.	F 812	Criteria 1 a. On 6/11/24 after being made aware of the concern for clean and sanitary floors, the dietary manager thoroughly cleaned the kitchen floor and under workstations. b. On 6/11/24 after being made aware of the concern regarding an opened nutritional supplement and an opened ready to use container of applesauce that did not contain an open date or use by date, the items were discarded by the Administrator. c. On 6/11/24 after being made aware of the concern regarding the ice scoop noted to be sitting in water, the ice scoop and holder were removed by the Administrator and cleaned by the dietary staff. d. On 6/11/24, the shredded cheese with no open or use by date was discarded by the dietary manager. Criteria 2 a. On 6/27/24, the dietary manager completed an audit of kitchen floors and under workstations. The floors and workstations were found to be clean. b. On 6/27/24, the dietary manager	

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F 812	Continued From page 9 b. An observation of the 300-nourishment room refrigerator was conducted on 6/11/24 at 10:54 AM with the District Food Service Manager and a Dietary Aide. The refrigerator contained an opened nutritional supplement and an opened ready to use container of applesauce that did not contain an open date or use by date. Dietary Aide #1 stated on 6/11/24 at 11:01 AM she had checked all the nourishment rooms around 7:00 AM that day and did not see the open items. c. An observation of the 300-nourishment room on 6/11/24 at 11:14 AM with the District Food Service Manager and Dietary Aide #1 found a cart that contained an ice chest with an ice scoop and ice scoop holder attached to the cart. The ice scoop was observed to be in the ice scoop container with approximately 2 inches of water and the tip of the scoop was resting in the water. The water contained multiple black and brown specks. The District Food Service Manager stated during the observation that the kitchen was not responsible for ensuring the ice carts were taken to the kitchen for cleaning. She stated the kitchen did not provide or replace the equipment on the ice cart and that the nursing department kept up with the daily maintenance of the ice carts. Dietary Aide #1 stated on 6/11/24 at 11:16 AM the ice carts were brought to the kitchen by nurses or nursing aides and left at random times during the day to be washed and sanitized. Dietary Aide #1 was not sure when the cart had last been cleaned.	F 812	completed an audit of all nourishment room refrigerators to determine if there were any out of date or unlabeled items present. No additional items were identified. c. On 6/27/24, the dietary manager completed an audit of the 300-hall ice scoop to determine if it was clean and/or standing in water. The ice scoop was found to be clean with no water in the holder. d. On 6/27/24, the dietary manager completed an audit of the walk-in cooler to determine if any items were present with no open or use by date. No items were found. Criteria 3 All residents have the potential to be affected by the deficient practices. On or before 6/30/24, the Administrator or designee educated all nursing staff and dietary staff that prepared food or open items placed in nourishment room refrigerators must be labeled with the date they are prepared and discarded no more than 7 days after that date. Shelf stable items with a manufacturer expiration date will be discarded no later than the expiration date on the label. Education also included the requirement to store ice scoops in a clean holder without standing water. Additionally, ice scoops should be sent to the kitchen daily for cleaning. Newly hired or agency staff members will be trained prior to working in the facility. On or before 6/30/24, the Administrator or designee educated all dietary staff on the	

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F 812	Continued From page 10 The Director of Nursing (DON) was interviewed on 6/12/124 at 1:20 PM. She stated the ice carts were taken down to the kitchen each morning by the nurses or nursing aides to be cleaned and sanitized. The ice cooler, ice scoops and ice scoop holders were removed from the cart, cleaned and replaced. The DON said the ice carts were then retrieved by the nurses or nursing aides and taken back to each nursing unit. The DON stated the ice scoop holder should not have contained water and the ice scoop should not have been touching the water. d. An observation of the walk-in refrigerator on 6/11/24 at 11:57 AM with the DM found a bag of shredded cheese on a storage shelf that did not have an open or use by date. The DM immediately removed the shredded cheese from the walk-in refrigerator. The Dietary Manager (DM) was interviewed on 6/11/24 at 1:37 PM. The DM stated the opened shredded cheese found in the walk-in refrigerator should have contained an open date and use by date. He said the shredded cheese was used to make salads for the lunch meal that day and was placed back into the walk-in refrigerator without being dated. The DM stated he did checks in the morning to look for expired and non-dated food and did not find any. The DM said the items found in the 300-nourishment refrigerator should have been dated when opened before placing them into the refrigerator. He said the nourishment rooms were checked each day in the morning, and the opened items found were not in the refrigerator when checked that morning. The DM stated the kitchen floors are spot swept and moped several times each day, and that walking on the floor before it dried kept	F 812	kitchen cleaning schedule and the requirement to complete the assigned cleaning tasks on a daily basis including floors and under workstations. Education also included the requirement of labeling food items placed in the cooler to include an open date and a use by date. Newly hired staff members will be trained prior to working in the facility. Criteria 4 a. The dietary manager will audit kitchen floors 5 times per week for 4 weeks, then 3 times per week for 4 weeks to ensure the floors are clean and there is no debris under workstations. b. The dietary manager will audit a nourishment room refrigerator 5 times per week for 4 weeks, then 3 times per week for 4 weeks to ensure there is a date on all prepared food items and all food items are discarded no more than 7 days after that date. c. The dietary manager will audit the 300-hall ice scoop 5 times per week for 4 weeks, then 3 times per week for 4 weeks to ensure the scoop is clean and stored with no standing water. d. The dietary manager will audit the walk-in cooler 5 times per week for 4 weeks, then 3 times per week for 4 weeks to ensure that all food items are labeled with an open date and use by date. The facility administrator will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. Date of compliance is 7/1/24	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT WEAVERVILLE	78 WEAVER BOULEVARD WEAVERVILLE, NC 28787

(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
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the floor from looking clean. He stated the kitchen floor was hosed two times a week on Sunday and Wednesday, and the floor was not hosed on the previous Sunday. The DM stated the cleaning list schedule was assigned to the job (Cook, dietary aide) each shift and not to an individual staff member. The cleaning list schedule was not signed or marked by the staff when a cleaning task was completed, and the DM would check to ensure the cleaning was completed.

The Administrator was interviewed on 6/12/24 at 2:23 PM. He stated the kitchen had a performance improvement project (PIP) that began in July 2023. The PIP included properly dating and labeling food and the dietary staff had been educated and in serviced several times. He said audits of the kitchen had been ongoing and could not provide explanation for the food items found that were not dated. The Administrator stated the kitchen needed to utilize the cleaning list schedules to ensure cleaning tasks had been assigned and completed. The Administrator stated the ice chest and ice scoops should be cleaned and sanitized when dirty and as scheduled.