| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/31/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE GREENS AT WEAVERVILLE | 78 WEAVER BOULEVARD , WEAVERVILLE, North Carolina, 28787 |

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| E0000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 07/28/25 through 07/31/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D1A34-H1. | E0000 | | 08/15/2025 |
| F0000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey were conducted from 07/28/25 through 07/31/25. Event ID# 1D1A34-H1. The following intakes were investigated: 851377, 851379, 851386, 851388, 851390, 851393, 851397, 851402, 851405 and 2564502.<br><br>15 of the 15 complaint allegations did not result in deficiency. | F0000 | | 08/15/2025 |
| F0656<br>SS = D | Develop/Implement Comprehensive Care Plan<br><br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized | F0656 | Criteria 1<br><br>On 7/31/25 care plan for resident #86 was corrected by including the appropriate care plan and interventions to reflect the use of antipsychotic medication.<br><br>Criteria 2<br><br>All residents receiving antipsychotics are at risk for the alleged deficit practice.<br><br>On 8/12/25 an audit of care plans for all residents who receive antipsychotic medications was completed by Minimum Data Set (MDS) nurses to ensure that care plans were for the use of antipsychotic medication was present. No additional issues were noted.<br><br>Criteria 3<br><br>On 8/14/25, all MDS nurses were educated by the regional director of clinical reimbursement on the requirement to care plan the use of antipsychotic medication.<br><br>Criteria 4<br><br>An MDS nurse will audit 5 residents who use antipsychotic medication care plans per week for 8 | 08/15/2025 |

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 reverse for further 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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0656 SS = D | Continued from page 1<br>rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative(s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br><br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(iii) Be culturally-competent and trauma-informed.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interviews, the facility failed to care plan a resident who had a physician's order for an antipsychotic medication. This was for 1 of 5 residents reviewed for unnecessary medication (Resident #86).<br><br>Findings included<br><br>Resident #86 was admitted on 5/7/25 with diagnoses that included adjustment disorder.<br><br>Resident #86's admission Minimum Data Set (MDS) assessment dated 5/10/25 coded her cognitively intact and indicated she had received an antipsychotic during the 7-day look back period.<br><br>Resident #86 had a physician's order dated 6/23/25 for quetiapine fumarate oral tablet 50 milligram (antipsychotic). With instructions to give 1 tablet by mouth at bedtime for adjustment disorder with other symptoms.<br><br>A review of Resident #86's care plan that was dated last reviewed on 6/30/25 found no care plan for | F0656 | Continued from page 1<br>weeks to ensure that appropriate care planning for antipsychotic medication is present.<br><br>The administrator will review monitoring results and report to Quality Assurance Process Improvement (QAPI) meetings monthly until substantial compliance has been met.<br><br>Date of Compliance: 8/15/2025 | |

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| F0656 SS = D | Continued from page 2<br>antipsychotic medication use.<br><br>On 7/31/25 at 10:22 AM, MDS Nurse #1 stated Resident #86's care plan had not included a care plan for an antipsychotic medication. MDS Nurse #1 added the physician's order for an antipsychotic medication was added on 6/23/25 and should have been care planned for Resident #86. All new physician's orders are reviewed each morning during the interdisciplinary team (IDT) meeting and Resident #86's antipsychotic medication order was missed.<br><br>The Administrator was interviewed on 7/31/25 at 2:56 PM. She stated all residents who had received an antipsychotic medication needed to have a care plan for antipsychotic medication. The care plan needed to be added when the medication was ordered for the residents. The Administrator stated the order for the antipsychotic medication was missed when reviewed by the MDS nurses during the IDT morning meeting the morning after the order was written. | F0656 | | |
| F0812 SS = E | Food Procurement,Store/Prepare/Serve-Sanitary<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br><br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(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.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by: | F0812 | Criteria 1:<br><br>On 7/28/25, after being made aware of the concern of a personal drink being in the cooler. The personal drink was discarded.<br><br>On 7/28/25, after being made aware of the concern of squash being beyond use, the squash in question was discarded.<br><br>Criteria 2<br><br>All residents have the potential to be affected by the alleged deficit practices.<br><br>On 7/28/25, the dietary manager completed an audit of the cooler to determine if there were any personal drinks in the cooler. No additional items were identified.<br><br>On 7/28/25, the dietary manager completed an audit of cooler to determine if there were any expired foods. No additional items were identified<br><br>Criteria 3<br><br>On or before 8/1/2025 the administrator or designee | 08/15/2025 |

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| F0812<br>SS = E | Continued from page 3<br>Based on observations and interviews with staff, the facility failed to remove expired food with signs of spoilage stored for use in 1 of 3 refrigerators (the walk-in refrigerator). This had the potential to affect food served to the residents in the facility.<br><br>Findings included<br><br>On 7/28/25 at 10:15 AM an observation with the Dietary Manager (DM) in the walk-in refrigerator found a box of yellow squash with a written date of 7/9. The box of yellow squash was located underneath an additional box of yellow squash with a written date of 7/14 stored on the second shelf. The yellow squash dated 7/9 were observed to contain dark, splotchy and sunken in areas and the squash was not firm to touch. Furthermore, 1 squash located in the bottom of the box was broken into two pieces and was mushy when touched. The DM stated during the observation the yellow squash needed to be thrown out. The DM immediately removed and threw away the yellow squash.<br><br>A follow-up interview with the DM was conducted on 7/31/25 at 12:56 PM. He stated it was his responsibility to check all food storage areas in the kitchen every morning for expired or out of date food. The DM stated he had checked the walk-in refrigerator on 7/28/25 prior to the observation with the state surveyor and he had overlooked the bad squash.<br><br>The Administrator was interviewed on 7/31/25 at 2:56 PM. The Administrator stated any food past expiration or produce that had gone bad should have been discarded. | F0812 | Continued from page 3<br>educated all dietary staff on proper storage of personal drinks. Education also included the requirement to discard perishable or out of date items before they deteriorate beyond a state of optimal use.<br><br>Criteria 4<br><br>The dietary manager will audit the cooler 3 times a week per week for 8 weeks to ensure no personal drinks are in the cooler.<br><br>The dietary manager will audit the cooler 3 times a week per week for 4 weeks to ensure no perishable items are deteriorated beyond optimal use.<br><br>The facility administrator will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.<br><br>Date of compliance is: 8/15/2025 | |