

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER The Greens at Weaverville		STREET ADDRESS, CITY, STATE, ZIP CODE 78 Weaver Boulevard Weaverville, NC 28787	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Medical Director, Nurse Practitioner and staff interviews, the facility failed to follow the physician's order and obtain a blood pressure reading prior to administering a blood pressure medication with parameters to hold for 1 of 3 residents reviewed for change of condition (Resident #136). Findings included: Resident #136 was admitted to the facility on [DATE] with diagnoses including hypertension and chronic systolic congestive heart failure. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #136's cognition was severely impaired. The MDS list of active diagnoses included hypertension. Resident #136's physician's order written on 05/08/26 for metoprolol (beta blocker) 25 milligram (mg) give half tablet (12.5 mg) one time a day for hypertension, hold if the systolic blood pressure (maximum pressure in the arteries when the heart contracts) was less than 100. Review of the June 2026 Medication Administration Record (MAR) revealed on 06/15/26 at 9:00 AM, Nurse #1 documented metoprolol 25 milligram (mg) give half tablet (12.5 mg) was administered. Resident #136's MAR included vital signs as follows: blood pressure, temperature, pulse, respiratory rate, and oxygen saturation with directions to obtain twice a day every day and evening shift from 7:00 AM through 3:00 PM and from 3:00 PM through 11:00 PM. Nurse #1 documented Resident #136's vital signs on 06/15/26 at 7:00 AM through 3:00 PM as follows: blood pressure (NA), temperature 97.4, pulse 78, respiratory rate 16, and oxygen saturation 93. There was no indication what time Nurse #1 took Resident #136's vital signs. Review of Resident #136's electronic medical records labeled vital signs revealed Nurse #1 documented a blood pressure of 90/52 on 6/15/26 at 10:47 AM. During an interview on 07/22/26 at 3:31 PM, Nurse #1 confirmed she had administered metoprolol on 06/15/26 as part of Resident #136's scheduled 9:00 AM morning medications and stated typically she checked the vital signs, including the blood pressure before giving the medications. Nurse #1 stated she could not confirm Resident #136's blood pressure was checked prior to administering the metoprolol. She revealed it was after the morning medications were administered Resident #136's blood pressure result was 90/52 and she notified the Nurse Practitioner (NP). Interviews were conducted on 07/22/26 at 11:21 AM and 07/22/26 at 2:32 PM with the NP. The NP confirmed the physician's order included a parameter to hold if Resident #136's systolic blood pressure was less than 100 and required Nurse #1 to check the blood pressure before administering the metoprolol. The NP confirmed Nurse #1 notified her on 06/15/26 when the blood pressure was 90/52 and stated Resident #136 had received metoprolol for some time and she did not consider a 12.5 mg dose was significant to cause a negative change in Resident #136's condition. During an interview on 07/23/26 at 10:22 AM, the Medical Director revealed Resident #136's blood pressure was checked twice a day, and the results were reviewed, and if consistently low the medication metoprolol would have been discontinued. The Medical Director stated based on Resident #136's blood pressure results, administering a 12.5 mg dose of metoprolol, she did not consider that (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 345221
		If continuation sheet Page 1 of 6

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	caused a negative change in Resident #136's condition. During an interview on 07/23/26 at 4:13 PM, the Director of Nursing (DON) revealed the physician's order required Nurse #1 check Resident #136's blood pressure prior to administering metoprolol and if not done was an oversight.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff and resident interviews, the facility failed to provide incontinence care for 1 of 5 dependent residents (Resident #103) reviewed for activities of daily living. The findings included: Resident #103 was admitted on [DATE] with diagnoses including chronic kidney disease, mild cognitive impairment, and benign prostatic hyperplasia (enlarged prostate). Resident #103's Care Plan revised 6/11/26 had focus areas for: Activities of daily living (ADL) self-care deficit with interventions including - to encourage use of call light for assistance, provide assistance with toileting and dressing as needed. Incontinence of bladder with interventions including - uses disposable briefs, check and change on routine rounds, assist to bathroom or provide incontinence care as needed, and keep call light in easy reach. Potential impairment to skin integrity related to incontinence and effects of diagnoses with interventions including - observe skin status during routine care, keep skin clean and dry. The quarterly Minimum Data Set (MDS) dated [DATE] for Resident #103 showed him to be moderately cognitively impaired, with no impairment of upper or lower extremities, frequent incontinence of bowel and bladder, and no skin problems or moisture associated skin damage. He was also coded for renal insufficiency, without rejection of care, being dependent for toileting hygiene and bathing, and required substantial assistance with transfers and toileting transfers. On 7/20/26 at 9:50 AM during an observation of Resident #103 while in bed, a strong odor was detected in the room which smelled like urine. In an interview during the observation Resident #103 was able to answer simple questions with short answers and stated he had a problem, he was wet. He also stated he had eaten breakfast in bed but was unable to explain how long he had been wet or if he had eaten breakfast while wet. Closer observation revealed Resident #103 to be wearing sweat pants which were partially pulled down over his hips, and he was not wearing a brief or undergarment. Resident #103's blanket and top sheet were bunched up between his thighs and the blanket, top sheet, sweat pants, draw sheet (a flat sheet folded in half and placed under the resident's hips to assist in bed positioning), and bottom sheet were wet and had the odor of urine and he was pulling on the blanket. No incontinence pad or used brief were observed on the bed or anywhere in the room. A small garbage can with no liner was next to Resident #103's bed which contained 1/4 inch of yellow liquid that had the appearance of urine. He did not answer when asked if he had urinated in the trash can. When asked if he had used the call bell to let someone know he was wet, Resident #103 stated he did not know where it was. The call bell was observed to be clipped on the fitted sheet above his left shoulder, next to the pillow near the top of the mattress and was partly covered by the top sheet. Record Review of Resident #103's Urinary Report from 7/19/26 at 11:00 PM to 7/20/26 at 9:50 AM indicated a continent urination on 7/20/26 recorded at 12:54 AM by Nurse Aide (NA) #4 with no other entries observed. A phone interview was conducted with NA #4 on 7/22/26 at 4:53 PM who stated she worked 11:00 PM on 7/19/20 until 7:00 AM on 7/20/26 and was assigned to Resident #103 that shift and it had been her first time taking care of him. NA #4 explained she got shift change report from the off-going NA but didn't remember their name. She further explained she had been told in report that Resident #103 used the toilet, didn't like to use briefs, and used the urinal at times, but had episodes of confusion and would sometimes urinate in a cup and added that she hadn't been told he also urinated in the waste basket at times. NA #4 described seeing Resident #103 sitting on the side of the bed about 12:00 or 12:15 AM, asked if he needed to go the bathroom, then assisted him to the bathroom because he was a little wobbly, that he urinated in the toilet and then went back to sleep in bed. NA #4 revealed she did rounds on the hall about every 2 hours through the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	night and each time she looked in on Resident #103 he was sleeping and didn't check to see if he was wet because of what she had been told in report. NA #4 stated she was last in Resident #103's room and saw him sleeping about 6:00 AM and did not remember a urine odor then. NA #4 concluded the interview by stating she had access to the resident's care guides on the computer system and had logged on to see her residents' code status but didn't need to look at what care to provide because she had gotten that information in report. On 7/20/26 at 9:56 AM an interview was conducted at Resident #103's bedside with Nurse Aide (NA) #1 who was his NA. He explained he had taken care of Resident #103 several times including last evening until 11:00 PM and had put a brief on him about 10:00 PM. NA #1 further explained he had come in at 7:00 AM today and hadn't changed him yet but could see that he was wet now. NA #1 revealed he had noticed the urine smell around 7:30 to 7:45 AM when he first went into Resident #103's room but did not look to see if he was wet because there were no briefs in his room and planned to change him when he got some briefs. NA #1 stated there were no briefs on the hall storage cart or in the storage room and he had let Nurse #2 know briefs were needed for the hall cart. NA #1 further explained that supplies were stocked every morning but sometimes not until breakfast time. During a follow up interview with NA #1 at 10:23 AM he stated when he smelled urine earlier he did not change Resident #103 because there were no briefs and he had not looked to know that Resident #3 wasn't wearing a brief because he usually wore one at night and added that he sometimes would take his briefs off. NA #1 added he did get briefs and then breakfast trays came and he did not like to change residents right when the food was coming, that trays had come about 8:15 AM and he had been planning to do rounds right after breakfast. An interview was conducted at Resident #103's bedside with Nurse #2 who was his nurse, on 7/20/26 at 10:11 AM. Nurse #2 confirmed that Resident #103 was wet through this sweatpants, blanket, and sheets and they smelled of urine. She stated there were times when Resident #103 would remove used briefs and put them on the floor but there were no incontinence pads or used briefs on the bed or in the room now. Nurse #2 also confirmed there was urine in the trash can beside his bed and explained he would sometimes urinate in the trash can. Nurse #2 revealed she had been in his room about 7:25 AM to see if he was awake and did not remember if she smelled urine and hadn't looked to see if he was wet, she was just doing quick checks see if residents were awake. She did not recall if she had seen his call bell and stated he sometimes used his call bell, but she hadn't seen that he had used it that morning. Nurse #2 explained the NAs got briefs from the supply room to put on the hall carts, the supply room had been stocked that morning but wasn't sure what time, and the NAs could get briefs from another hall cart if needed. An observation was made on 7/20/26 at 10:15 AM of NA #1 and Nurse #2 assisting Resident #103 to the bathroom for toileting and incontinence care. When Resident #103 stood it was observed that both mid to upper buttocks cheeks had palm-shaped, 6 to 7-inch high by 4 - 5 inches wide red marks with shallow wrinkles consistent with maceration (skin condition from exposure to moisture). On Resident #103's upper left buttock and lower back were multiple 1/2 to 1-inch reddened marks in a 4-inch area which had the appearance of scratches. During the observation Nurse #2 confirmed that Resident #103 had red marks on his buttocks and lower back that had the appearance of maceration and scratches and added that sometimes he would scratch himself. Nurse #2 was unaware of how long it had been since Resident #103 had been changed and had not known about the red marks on his buttocks. In an interview with NA #2 who was Resident #103's NA that shift on 7/22/26 at 4:19 PM, she explained he used to use the urinal during the day and a wear brief at night but would often refuse to wear a brief during the day. She further explained he would still sometimes urinate in the toilet and would try to use the urinal but had a hard time managing it. She added that he would occasionally urinate in the trash can but was mostly incontinent (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at this point. NA #2 stated he did sometimes still used the call bell but not a lot anymore. NA #2 revealed he was mostly using a brief during the day for about the last few weeks, and they had him on routine checks to be changed every few hours. NA #2 revealed she had seen times when she came in the morning when he was not wearing a brief but not seen him having been wet in the bed. On 7/22/26 at 4:26 PM an interview was conducted with NA #3 who had worked with Resident #103 for several years and was assisting NA #2 with his care today. She stated he would sometimes use the urinal but would pull it away before he was finished and dribble on the sheets. NA #3 explained he used to have the habit of pulling briefs off wet or dry, but recently saw he was in a brief a lot when she came on in the morning and had seen him wet a few times at shift change but not all the time. She further explained he was wearing briefs during the day more often recently and staff would put an incontinence pad as well to catch drips because he would sometimes open the brief and try to use the urinal which would usually spill, or he would sit on the bed side and urinate in the trash can. During an interview with the Director of Nursing (DON) on 07/22/26 at 5:46 PM she stated staff did rounds every few hours to check and change incontinent residents. The DON explained the expectation was when it was known a resident had an incontinent episode staff should provide care as soon as possible. She further explained the NAs have access to briefs on the carts on each hall and if they ran out on the cart they could get some from another hall cart or ask any nurse to get more from the supply room. The DON revealed that NA #1 should have provided incontinence care to Resident #103 when he first noticed the urine odor at the start of the shift and NA #4 should have gotten information in report to have known to check him. The Administrator was interviewed on 7/22/26 at 5:48 PM and explained the facility had had plenty of incontinence supplies and the supply room was stocked every day. During the interview, observation was made of the supply room which contained multiple packages of briefs in a variety of sizes. The Administrator explained that Resident #103 was sometimes continent, had been known to urinate in a cup or his trash can and when he did use the urinal he often spilled urine. She stated residents were to be changed on rounds every few hours and in between as needed and should not wait to provide incontinence care until after meals if they knew it was needed.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the Registered Dietitian (RD), Nurse Practitioner (NP) and staff, the facility failed to implement nutritional supplements for a resident with pressure ulcer wounds and non-pressure ulcer venous wounds as recommended by the RD for 1 of 4 residents reviewed for nutrition (Resident #136). Findings included: Resident #136 was admitted to the facility on [DATE] with diagnoses including a stage 3 sacrum pressure ulcer (full-thickness loss of skin, in which subcutaneous fat may be visible), a left heel deep tissue injury (intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue), and non-pressure chronic venous/arterial ulcers (an open lesion of the skin and subcutaneous tissue) of the right and left legs. The care plan dated 05/07/26 identified Resident #136 was at risk for malnutrition related dementia, pressure ulcer wounds, and non-pressure wounds. Interventions included continue dietary recommendations. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #136 was severely impaired cognitively, needed supervision assistance with eating, had one stage 3 pressure ulcer and one deep tissue injury that were present on admission, and 4 venous/arterial ulcers. Review of the RD's progress note dated 05/22/26 revealed Resident #136's evaluation noted she met approximately 60 to 80% of her estimated nutritional needs. The RD's note included Resident #136's stage 3 pressure ulcer, a left heel pressure ulcer, and arterial wounds and a recommendation for 120 milliliters (ml) daily nutritional drink supplement to provide an additional 240 calories and a therapeutic nutritional powder (amino acids and collagen protein) supplement twice a day to provide an additional 180 calories. Review of Resident #136's physician orders revealed no order for a 120 ml daily nutritional supplement drink or a therapeutic nutritional powder supplement twice a day. Resident #136 was discharged from the facility on 06/15/26. During an interview on 07/22/26 at 10:55 AM, the RD revealed she evaluated Resident #136's nutritional needs on 05/22/26. The RD stated she evaluated Resident #136's oral intake and estimated she was not meeting nutritional needs and recommended a daily 120 ml nutritional drink supplement and a therapeutic nutritional powder supplement twice a day to meet 100% of nutritional needs. The RD stated her recommendations were sent by email to the facility typically on the same day 05/22/26 and she included the Unit Manager, Assistant Director of Nursing (ADON), Director of Nursing (DON) on the email. The RD indicated Resident #136 was discharged from facility before the next monthly review. During an interview on 07/22/26 at 11:21 AM, the NP confirmed Resident #136's nutritional status was followed by the RD and included recommendations to improve oral intake. The NP was aware of Resident #136's stage 3 pressure ulcer, a deep tissue injury pressure ulcer, and non-pressure lower extremity vascular wounds and agreed with the RD recommendations made on 05/22/26 for Resident #136 to receive nutritional supplements and stated those should have been put in place. During an interview on 07/23/26 at 4:13 PM, the DON confirmed Resident #136 was evaluated by the RD on 05/22/26 and the recommendations were sent by email to her, the Unit Manager, and the ADON for review. The DON revealed she did not recall reviewing the recommendations made for Resident #136 on 05/22/26 to ensure those were implemented and stated it was the Unit Manager's responsibility to ensure the RD's recommendations were transcribed to Resident #136's Medication Administration Record.		