

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 06/12/2024
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)
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069</p> <p>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.</p> <p>The findings included:</p> <p>1. Resident #80 was originally admitted to the facility on [DATE] and was readmitted on [DATE].</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>(continued on next page)</p>

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
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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>49000</p> <p>2. Resident #86 was readmitted to the facility on [DATE] with the diagnosis of anxiety disorder and bipolar disorder.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49000</p> <p>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.</p> <p>The findings included:</p> <p>Resident #90 was admitted to the facility on [DATE] with the diagnoses of diabetes and a pressure ulcer on left buttocks.</p> <p>On 2/1/24 Resident #90 was weighed using a sit-down scale and his weight was 253.0 pounds.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #90 was alert and cognitively intact. He had no weight loss.</p> <p>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.</p> <p>On 4/24/24 Resident #90 was weighed using a total mechanical lift and his weight was 229.4 pounds.</p> <p>5/28/24 Resident #90 was weighed using a total mechanical lift and he weighed 215.8 pounds.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>On 6/11/24 at 4:09 PM an interview was conducted with the Dietary District Manager (DDM) and Dietary Manager (DM). The DDM 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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272</p> <p>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.</p> <p>The findings included:</p> <p>a. An observation of the kitchen on [DATE] 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.</p> <p>An observation of the kitchen floor on [DATE] 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.</p> <p>b. An observation of the 300-nourishment room refrigerator was conducted on [DATE] 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.</p> <p>Dietary Aide #1 stated on [DATE] at 11:01 AM she had checked all the nourishment rooms around 7:00 AM that day and did not see the open items.</p> <p>c. An observation of the 300-nourishment room on [DATE] 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.</p> <p>Dietary Aide #1 stated on [DATE] 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.</p> <p>The Director of Nursing (DON) was interviewed on [DATE] 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.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. An observation of the walk-in refrigerator on [DATE] 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.</p> <p>The Dietary Manager (DM) was interviewed on [DATE] 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 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.</p> <p>The Administrator was interviewed on [DATE] at 2:23 PM. He stated the kitchen had a performance improvement project (PIP) that began in [DATE]. 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.</p>		