STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345221	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Weaverville	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). Findings includedResident #86 was admitted on [DATE] with diagnoses that included adjustment disorder. Resident #86's admission Minimum Data Set (MDS) assessment dated [DATE] coded her cognitively intact and indicated she had received an antipsychotic during the 7-day look back period. 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. A review of Resident #86's care plan that was dated last reviewed on 6/30/25 found no care plan for antipsychotic medication use. 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.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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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.Findings includedOn 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. 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.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.