STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Green Health and Rehabilitation	1601 Purdue Drive Fayetteville, NC 28304

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident who was admitted to the facility with a serious mental health disorder for 1 of 3 residents reviewed for PASRR (Resident #1).Findings included:Resident #1's Hospital Course and Treatment Encounter Note dated 2/21/26 indicated Resident #1's chronic conditions included post-traumatic stress disorder (PTSD) which was monitored during that hospitalization. A PASRR Determination Notification letter dated 2/26/26 revealed Resident #1 had a Level I PASRR with no expiration date.A North Carolina Medicaid FL2 Level of Care Screening Tool (a medical document completed by a physician which certifies a patient's need for a specific level of care in a long-term care facility) signed by the hospital Social Worker on 3/19/26 and submitted to the facility did not include a diagnosis of PTSD. Resident #1 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD) and PTSD. Resident #1's care plan had a care focus area initiated on 3/25/26 that indicated that he was at risk for impairments or complications due to a history of PTSD with the goal for Resident #1 to feel safe and secure in his environment. Interventions included approach in a calm and respectful manner, avoid triggers/actions that can cause relapses or crisis, build a trusting relationship with the resident, obtain psychiatric referral as needed and include resident in decision making regarding care. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #1's active psychiatric/mood disorder diagnoses included (PTSD). He received an antidepressant medication during the MDS assessment review period. During an interview on 5/5/26 at 3:29 PM with the facility Social Worker (SW), she revealed that she was responsible for submitting requests for Level II PASRR evaluations. She stated that Resident #1 had a diagnosis of PTSD which was not included on the FL2 that was submitted by the hospital. The SW stated that she completed her audits on a quarterly basis where she reviewed the admission paperwork to include hospital records and the MDS to identify the diagnoses that required submission for PSARR evaluations. She reported that she was in the process of completing audits for PASRR screening and was getting ready to submit them including one for Resident #1. An interview was conducted on 5/6/26 at 3:24 PM with the Administrator. She stated that the Social Worker should have submitted a request for a Level II PASRR evaluation for Resident #1 with all the diagnoses to include PTSD when he was admitted to facility. The Administrator explained that the Social Worker was supposed to review the admission diagnoses and those that triggered in the MDS and request a Level II PASRR evaluation within a month of admission or new diagnosis and not on a quarterly basis to ensure requests were submitted in a timely manner.

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