STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345123	A. BUILDING _____ B. WING _____	10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA VILLAGE INC	600 CAROLINA VILLAGE ROAD SUITE Z HENDERSONVILLE, NC 28792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted 10/10/23 through 10/13/23. The facility was found in compliance with the requiurement CFR 483.73, Emergency Preparedness. Event ID# 97RR11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification Survey was conducted on 10/10/23 through 10/13/23. Event ID# 97RR11.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		10/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/30/2023

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.

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F 640	Continued From page 1 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete discharge assessments within the regulatory timeframes for 4 of 4 sampled residents reviewed for resident assessment (Residents #38, #8, #24, and #22). The findings included: 1. Resident #38 was admitted to the facility on 4/24/23. Facility documentation indicated Resident #38 had been discharged on 5/11/23. Review of Resident #38's Minimum Data Set (MDS) assessments revealed no discharge	F 640	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; For the four residents identified who did not have their discharge MDS assessment done, they were completed and transmitted to CMS by 10/13/2023. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 640	Continued From page 2 assessment had been completed. An interview on 10/13/22 at 10:00 am with the MDS Coordinator revealed the resident did not have a discharge MDS assessment. She stated that she had missed it. She was unable to remember who had been discharged, because once the resident was discharged from the facility computer system, they were no longer on her MDS calendar. The MDS Coordinator demonstrated how she created a discharge report and how she completed assessments from the list. She indicated she needed to develop a better tracking system. An interview with Director of Nursing (DON) on 10/13/23 at 10:12 AM revealed the discharge MDS assessment for Resident #38 should have been completed at discharge. 2. Resident #8 was admitted to the facility on 5/5/23. Facility documentation indicated Resident #8 had been discharged on 5/27/23. Review of Resident #8's Minimum Data Set (MDS) assessments revealed no discharge assessment had been completed. An interview on 10/13/22 at 10:00 am with the MDS Coordinator revealed the resident did not have a discharge MDS assessment. She stated that she had missed it. She was unable to remember who had been discharged, because once the resident was discharged from the facility computer system, they were no longer on her MDS calendar. The MDS Coordinator demonstrated how she created a discharge report and how she completed assessments from the list. She indicated she needed to develop a	F 640	MDS Coordinator and Director of Nursing printed off a discharged resident report going back to April of 2023 and checked on any additional residents who did not have a discharge MDS assessment completed. Any that were not done were finished and transmitted to CMS by 10/20/2023. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; MDS Coordinator is now utilizing a paper calendar in which any resident who is scheduled to be discharged is added to the paper calendar to avoid any chance of missing a discharge assessment. This paper calendar will be submitted to the Director of Nursing or designee based off the parameters listed below. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; In addition to the paper calendar, the MDS Coordinator will report to the Director of Nursing or designee their review/completion of discharge MDS assessments on the following schedule: 5x a week for two weeks, 3x a week for two weeks, 1x a week for two weeks then Monthly for three months. Reports of findings will be discussed in facility QAPI meeting. This started the week of 10/30/2023.	

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F 640	Continued From page 3	F 640		

better tracking system.

An interview with Director of Nursing (DON) on 10/13/23 at 10:12 AM revealed the discharge MDS assessment for Resident #8 should have been completed at discharge.

3. Resident #24 was admitted to the facility on 5/27/23.
Facility documentation indicated Resident #38 had been discharged on 8/15/23.
Review of Resident #24's Minimum Data Set (MDS) assessments revealed no discharge assessment had been completed.

An interview on 10/13/22 at 10:00 am with the MDS Coordinator revealed the resident did not have a discharge MDS assessment. She stated that she had missed it. She was unable to remember who had been discharged, because once the resident was discharged from the facility computer system, they were no longer on her MDS calendar. The MDS Coordinator demonstrated how she created a discharge report and how she completed assessments from the list. She indicated she needed to develop a better tracking system.

An interview with Director of Nursing (DON) on 10/13/23 at 10:12 AM revealed the discharge MDS assessment for Resident #24 should have been completed at discharge.

4. Resident #22 was admitted to the facility on 5/25/23.
Facility documentation indicated Resident #22 had been discharged on 6/20/23.
Review of Resident #22's Minimum Data Set (MDS) assessments revealed no discharge

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F 640	Continued From page 4 assessment had been completed. An interview on 10/13/22 at 10:00 am with the MDS Coordinator revealed the resident did not have a discharge MDS assessment. She stated that she had missed it. She was unable to remember who had been discharged, because once the resident was discharged from the facility computer system, they were no longer on her MDS calendar. The MDS Coordinator demonstrated how she created a discharge report and how she completed assessments from the list. She indicated she needed to develop a better tracking system. An interview with Director of Nursing (DON) on 10/13/23 at 10:12 AM revealed the discharge MDS assessment for Resident #22 should have been completed at discharge.	F 640		