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	345312	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 and complaint investigation survey was conducted on 10/29/24 through 11/01/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# E4SJ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 10/29/24 through 11/01/24. Event ID# E4SJ11. The following intakes were investigated: NC00222816, NC00221885 and NC00221526. 2 of the 11 complaint allegations resulted in deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with staff the facility failed to provide a dependent and tall resident with a bed extender for (1 of 1) resident reviewed for accommodation of needs (Resident #256). Findings included: Resident #256 was admitted to the facility on 10/11/24. Resident #256 was admitted with diagnosis that included right side paralysis and healing from left	F 558	Criteria 1: On November 1, 2024, the Maintenance Director placed a bed extender on the bed for resident #256. Criteria 2: On November 1, 2024, an audit was completed by the administrator/designee to ensure that no other beds were found to be inadequate length for the resident. No additional concerns were identified. Criteria 3: On November 8, 2024, education for all staff was initiated by	11/11/24

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

Electronically Signed | 11/19/2024

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F 558	Continued From page 1 fibula fracture. A review of his medical record revealed his height was 72 inches tall. The admission Minimal Data Set (MDS) dated 10/17/24 coded Resident #256 as cognitively intact. The MDS coded Resident #256 as needing maximum 2-person assistance with transfers, and dependent with bed mobility. Resident #256 was care planned for activities of daily living (ADL) self-care performance deficit and required staff assistance to complete ADL tasks daily (10/17/24). Interventions included the resident's usual performance is to roll left to right, sitting to lying, and lying to sitting (dependent). An in-room observation was conducted in Resident #256's room on 10/29/24 at 10:50 AM. Resident #256 was observed laying in his bed with the head of the bed elevated. His body was positioned diagonally with his head and upper body on the resident's upper right corner of the bed and both his feet pressed against the left side of his bed's foot board. Further in room observation on 10/31/24 at 2:12 PM found Resident #256's feet pressed against the bed foot board. Resident #256 stated in an interview on 10/29/24 at 10:53 AM that he was too long for his bed and his feet were pushed against the foot board when he elevated the top of his bed. He stated it was hard for him to reposition up in his bed to keep his feet from touching the foot board. Additionally, he stated he was able to shift his body diagonally in his bed and it was more	F 558	administrator/designee that a resident's individual needs and preferences, including the need for a longer bed, will be evaluated on admission and reviewed on an ongoing basis. If a resident is identified by staff as having a need such as an extended bed or if the resident expresses a need to staff for an accommodation such as an extended bed, the staff member should report immediately to the supervisor and place in the maintenance book (located at the main nurse station) to notify the Maintenance Director that accommodation is needed. All staff, including agency staff, will have this education prior to working a shift Criteria 4: Beginning on 11/12/24, the administrator/designee will monitor this process by auditing 5 beds per week for 8 weeks to ensure that the bed is the appropriate length. The findings of these audits will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee for 2 months. Audits will continue at the discretion of the QAPI committee. Administrator is responsible for compliance. The date of compliance is 11/11/24.	

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F 558	Continued From page 2	F 558		

comfortable for him and his feet would not be pressed against the foot board. Resident#256 stated a few days after he had moved into his room, he told a staff he was too long for his bed, and he had not been placed in a longer bed and his feet had been pressed against the foot board since he was admitted. He was unable to recall who he had told he was too long for his bed. Resident #256 stated he was paralyzed on his right side of the body and could not reposition easily to prevent his feet from touching the foot board.

The Physical Therapist (PT) was interviewed on 10/31/24 at 9:13 AM. The PT stated Resident #256 was receiving PT to work on safety awareness to operate in his home. His goals included to do stand and pivot transfers. Resident #256 had halo bed rails placed on his bed to help with repositioning in bed on 10/17/24. The PT stated Resident #256's body did shimmy down his bed when the head of bed is elevating causing his feet to touch the foot board. The PT said the maintenance department would install bed extenders on beds and he was unaware if maintenance had been notified about the bed extender.

Resident #256's Occupational Therapist Assistant (COTA) was interviewed on 10/31/24 at 9:44 AM. She stated Resident #256 was working on strengthening his core and balance for upper body strength so he could pull himself up in bed. She stated Resident #256 would benefit from an extended bed to keep his feet from touching the footboard. The COTA said Resident #256 had made comments to her that he felt really long in his bed, and she had seen his feet touching the foot board. She said Resident #256 did slide

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F 558	Continued From page 3	F 558		

down in his bed when the head of the bed was elevated, and she would help the resident slide his body back to the top of the bed.

Resident #256's assigned Nursing Assistant (NA) #1 was interviewed on 10/31/24 at 11:56 AM. She stated she had been assigned to Resident #256 when she worked from 7:00 AM to 7:00 PM. NA #1 stated she had seen that his feet would be pushed against his bed's foot board in the morning when she went into his room to check on him after starting her shift at 7:00 AM. NA #1stated Resident #256 had not complained to her about his feet touching the foot board. Resident #256 had told her he shifted his body diagonally in the bed to give his feet more room without touching the foot board. NA #1 said she would help reposition the resident in bed to make him more comfortable by sliding him up to the top of his bed. NA #1 stated she did not know a bed extender could be used to lengthen Resident #256's bed and had not told the nurse about Resident #256's feet touching the foot board.

The Maintenance Director was interviewed on 10/31/24 at 1:58 PM and stated he did install bed extenders on two beds and had not been notified Resident #256 needed a bed extender. He stated the nurses would normally let him know if a resident needed an extended bed and that he did have extenders available in the facility.

The Director of Nursing (DON) was interviewed on 11/1/24 at 2:25 PM. She stated Resident #256 was tall and did need a bed extender to prevent his feet from pressing against his foot board. The DON stated the resident's assigned NAs and Nurses needed to notify the Maintenance Director for a bed extender when identified.

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F 558	Continued From page 4 The Administrator was interviewed on 11/1/24 at 3:33 PM. She stated Resident #256's need for a bed extender should have been reported so it could have been addressed.	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting	F 584		11/11/24

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F 584	Continued From page 5 levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure the armrest of Resident #75's wheelchair remained in good repair for 1 of 3 wheelchairs observed for safe, clean and homelike environment. Findings included: Resident #75 was admitted to the facility on 03/24/22. The significant change Minimum Data Set (MDS) dated 09/13/24 revealed Resident #75 had severe cognitive impairment. During an observation on 10/29/24 at 12:28 PM Resident #75 was sitting up in his wheelchair in his room eating lunch. On the left side of Resident #75's wheelchair, the padded armrest was being held in place to the armrest frame by 4 rows of purple tape that were wrapped around the bar of the armrest frame and top of the padded armrest. The material of the padded armrest was not cracked, broken or frayed. Subsequent observations conducted on 10/30/24 at 8:55 AM and 10/31/24 at 1:45PM revealed the condition of the armrest on Resident #75's	F 584	Criteria 1: On October 31, 2024, the Maintenance Director replaced the wheelchair armrest for resident #75. Criteria 2: On October 31, 2024, an audit was completed by the administrator/designee to ensure that no other wheelchairs were found with loose armrests, tears in the upholstery, or other issues of disrepair. Any issues with medical equipment were repaired on October 31, 2024. Criteria 3: On November 8, 2024, education for all staff was initiated by administrator/designee that any equipment in disrepair such as a resident wheelchair, should be reported immediately to the supervisor and placed in the maintenance book (located at the main nurse station) to notify the Maintenance Director that repair is needed. All staff, including agency staff, will have this training prior to working a shift. Criteria 4: Beginning on 11/12/24, the administrator/designee will monitor this	

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F 584	Continued From page 6 wheelchair remained unchanged. During an interview on 10/31/24 at 1:49 PM, Nurse Aide (NA) #4 revealed Resident #75 usually sat up in his wheelchair when eating his meals. NA #4 stated when she noticed a wheelchair needing repair, she notified the Unit Manager or Nurse Supervisor who then notified the Maintenance Director. NA #4 confirmed the left armrest on Resident #75's wheelchair had purple tape wrapped around the wheelchair frame holding it into place. NA #4 stated she had not previously noticed the condition of the armrest on Resident #75's wheelchair and had not notified anyone that it needed repair. An observation of Resident #75's wheelchair and subsequent interview was conducted with the Maintenance Director on 10/31/24 at 1:57 PM. The Maintenance Director explained he replaced armrests on wheelchairs when informed by staff that repairs were needed but stated he had not been notified that the armrest on Resident #75's wheelchair needed to be replaced. The Maintenance Director confirmed the left armrest of Resident #75's wheelchair had 4 rows of purple tape wrapped around the wheelchair frame holding it into place and stated it was something that he should have been made aware of for repair to be made. During an interview on 10/31/24 at 2:15 PM, the Nurse Supervisor revealed staff usually let her know when repairs were needed and she informed the Maintenance Director. The Nurse Supervisor stated no one had mentioned anything to her regarding the armrest on Resident #75's wheelchair needing repaired.	F 584	process by auditing 5 wheelchairs per week for 8 weeks to ensure that the equipment is not in disrepair. The findings of these audits will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee for 2 months. Audits will continue at the discretion of the QAPI committee. Administrator is responsible for compliance The date of compliance is 11/11/24.	

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F 584	Continued From page 7 During an interview on 11/01/24 at 2:41 PM, the Director of Nursing (DON) stated staff should have notified the Maintenance Director when Resident #75's wheelchair armrest was noticed needing repair. During an interview on 11/01/24 at 3:42 PM, the Administrator stated she would have expected for staff to have notified the Maintenance Director that the armrest of Resident #75's wheelchair needed repair so that it could have been fixed sooner.	F 584		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with the staff the facility failed to ensure the air mattress settings matched the resident's current weight for 2 of 3 residents reviewed for pressure ulcers (Resident #41 and #37).	F 686	Criteria 1: On November 1, 2024, the Director of Nursing (DON) corrected the settings on the air mattress for residents #37 and #41 so that the setting was appropriate for the weight of the resident. Criteria 2:	11/11/24

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F 686	Continued From page 8 The findings included: 1. Resident #41 was admitted to the facility on 03/01/24 with diagnoses including age-related physical debility and Parkinson's disease. The quarterly Minimum Data Set (MDS) dated 09/11/24 indicated Resident #41 needed supervision/touching assistance to roll in bed and move from a sitting to lying position with no unhealed pressure ulcers or other skin conditions. The MDS noted a pressure reducing device was used for the bed. The care plan revised on 09/23/24 revealed Resident #41 was admitted to the facility with an unstageable pressure ulcer on the right buttocks that previously resolved but reopened on 09/23/24. Interventions included to monitor air mattress settings to ensure they were set to the resident's weight. The current physician orders included the use of an air mattress with directions to monitor the settings every shift and set to the resident's weight started on 09/23/24. A review of Resident #41's Medication Administration Record (MAR) for October 2024 included the physician order for an air mattress with directions to check the settings and set at the resident's weight. The checks were scheduled every shift from 7:00 AM through 7:00 PM and 7:00 PM through 7:00 AM and initialed by the nurses to indicate they checked the air mattress and the weight setting was correct from 10/01/24 through 10/31/24. A review of Resident #41's most current weight	F 686	On November 1, 2024, the DON/designee conducted an audit of all air mattresses to ensure that the settings on the air mattress were appropriate for the resident per physician's order. All air mattresses identified as not having the appropriate settings were corrected immediately. Criteria 3: On November 8, 2024, the DON/designee initiated education on air mattresses for all nurses. The education included that all residents on an air mattress have a physician's' order that indicates the appropriate setting. This setting is based on the manufacturer's recommendation and is designated for each resident based on his or her weight. The process for ensuring that the correct setting is maintained is through nurse observation of physician order and visualization of the air mattress settings each shift. The nurse must verify that the air mattress settings match the physician's order and then he or she must record this verification in the Medication Administration Record (MAR) when completed. All licensed nurses, including agency staff, will have this education prior to working a shift Criteria 4: Beginning on 11/12/24, the DON/designee will monitor this process by completing an audit of all air mattresses 3 x week for 8 weeks to ensure that the air mattress is on the correct setting per physician's order. The findings of these audits will be reported monthly to the Quality Assurance and Performance Improvement (QAPI)	

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F 686	Continued From page 9 documented on 10/17/24 was 148.4 pounds. An observation on 10/31/24 at 10:28 AM revealed Resident #41 resting in the bed on the air mattress. The air mattress setting for weight was set at approximately 182 pounds. During an observation and interview on 11/01/24 at 11:32 AM Nurse #2 confirmed she was the assigned nurse for Resident #41 on 10/31/24 from 7:00 AM through 7:00 PM. Nurse #2 observed the air mattress weight setting was approximately 182 pounds and revealed when she initialed the MAR she checked the air mattress pump to ensure it was functioning. Nurse #2 stated she did not check the weight settings on the air mattress to ensure it was correct based on the weight of Resident #41 and she did not change the weight settings on the air mattress. An interview was conducted on 11/01/24 at 11:33 AM with the Director of Nursing (DON). The DON stated the nurses should visually check the weight setting on the air mattress to ensure it was correct based on the resident's current weight. The DON adjusted the weight setting to Resident #41's current weight of 148.4 pounds. 2. Resident #37 was admitted to the facility on 06/18/20. Resident #37's diagnoses included dementia and malnutrition. A review of the current physician orders included the use of an air mattress with directions to ensure the setting matched Resident 37's current weight started on 06/19/24. The care plan revised on 08/05/24 identified	F 686	committee for 2 months. Audits will continue at the discretion of the QAPI committee. Administrator is responsible for compliance. The date of compliance is 11/11/24.	

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F 686	Continued From page 10	F 686		

Resident #37 as having the potential for developing a pressure ulcer related to needing assistance with bed mobility and refusal to wear and at times removed heel protector boots. Interventions included the use of an air mattress and ensure settings matched the current weight of the resident.

Resident #37's quarterly MDS assessment dated 08/09/24 indicated there were no unhealed pressure ulcers or other skin issues and a pressure reducing device was used for the bed.

A review of Resident #37's most current weight documented on 10/18/24 was 95.5 pounds.

A review of Resident #37's MAR for October 2024 included the physician order with directions to check the air mattress to ensure the setting matched the resident's current weight. The checks were scheduled every shift from 7:00 AM through 7:00 PM and 7:00 PM through 7:00 AM and initialed by the nurses to indicate they checked the air mattress and the weight setting was correct from 10/01/24 through 10/31/24.

The weekly skin assessment date 10/28/24 revealed Resident #37 had no new skin abnormalities.

Observations on 10/29/24 at 3:02 PM and 10/30/24 at 3:51 PM revealed Resident #37 resting in bed on the air mattress. The weight setting on the air mattress was set at approximately 252 pounds.

During an interview and observation on 11/01/24 at 11:18 AM Nurse #1 confirmed she was the assigned nurse for Resident #37 on 10/29/24 and

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F 686	Continued From page 11 10/30/24 from 7:00 AM through 7:00 PM. Nurse #1 observed the weight setting on the air mattress was approximately 252 pounds and stated that was incorrect and she knew Resident #37 did not weigh that much. An interview and observation was conducted on 11/01/24 at 11:23 AM with the Director of Nursing (DON) in the presence of Nurse #1. The DON observed the weight setting on the air mattress was approximately 252 pounds and stated Resident #37's current weight was 95 pounds. It was shared with the DON the weight setting was observed at 252 pounds on 10/29/24 and 10/30/24 and had not changed. The DON stated when the nurses initialed the MAR they should visually check the weight setting on the air mattress and ensure it was correct based on the resident's current weight. The DON changed the weight setting on the air mattress to match Resident #37's current weight. An interview conducted on 11/01/24 at 3:45 PM with the Administrator revealed when the nurses initialed the MAR for air mattress settings it was expected they visually checked the setting to ensure it was correct based on the resident's current weight.	F 686		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		11/11/24

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F 756	Continued From page 12 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Consultant Pharmacist and Nurse Practitioner (NP) interviews the facility failed to follow up on a consultant pharmacist recommended Gradual Dose Reduction attempt (GDR) for a resident. This was for 1 of 5 residents reviewed for unnecessary medications (Resident #13).	F 756	Criteria 1: Pharmacy recommendations had already been acted upon at the time of survey findings. Criteria 2: On November 1, 2024, the Director of Nursing (DON)/designee completed an	

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F 756	Continued From page 13 Findings Included: Resident #13 was admitted on 1/13/24 with diagnosis that included dementia and diabetes mellitus. A review of Resident #13's quarterly Minimal Dat Set (MDS) dated 8/12/24 coded her with severe cognitive impairment. She required supervision for eating and toileting, used a wheelchair for mobility and frequently incontinent of bowel and bladder. She was coded as receiving an antidepressant during the 7-day look back period. A review of the pharmacy recommendations dated 7/24/24 for Resident #13 indicated a Gradual Dose Reduction attempt (GDR) was recommended by the Consultant Pharmacist. The Nurse Practitioner (NP) agreed to the GDR for Trazadone 50 mg to Trazadone 25 mg once daily at hours of sleep (HS) and was signed on 9/10/24. The pharmacy recommendations for October 2024, recommended a GDR for Trazadone 50 mg to Trazadone 25 mg once daily at HS. The NP agreed to the GDR and signed the order on 10/19/24. A review of Resident #13's physician orders for September 2024 found that no order for Trazadone 25 mg had been entered on 9/10/24 or after that date. A review of Resident #13's physician orders for October 2024 found that Trazadone 50 mg was discontinued on 10/21/24. A physician's orders for Trazadone 25 mg once daily at HS was entered on 10/21/24.	F 756	audit of all pharmacy recommendations for the last 30 days to ensure that timely follow-up had occurred with the provider, and any new orders were executed immediately. There were no new issues identified through this audit. Criteria 3: On November 1, 2024, education was completed by the DON to both unit managers that when pharmacy recommendations are obtained, timely follow-up must occur with the provider and any order changes given because of the recommendation must be executed immediately. Any new member of nurse management will receive this education prior to working in the facility. Criteria 4: Beginning on 11/12/24, the DON/designee will monitor the process by auditing 10 pharmacy recommendation per month for 2 months to ensure that the recommendations had timely follow-up with the provider and that if new orders were given, these orders were executed immediately. The findings of these audits will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee for 2 months. Audits will continue at the discretion of the QAPI committee. Administrator is responsible for compliance. The date of compliance is 11/11/24.	

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A review of Resident #13's Medication Administration Record (MAR) for September 2024 found that the resident received Trazadone 50 mg once daily during HS every day after the signed order on 9/10/24.

A review of Resident #13's October 2024 MAR found the resident received Trazadone 50 mg daily during HS every day until 10/21/24. The MAR indicated that Trazadone 25 mg daily during HS was received by the resident beginning on 10/21/24.

The Consultant Pharmacist was interviewed via phone on 11/1/24 at 9:50 AM. She stated she recommended GDR for Resident #13 in her pharmacy review conducted on 7/24/24. The Consultant Pharmacist stated a facility has 30 days to respond to her recommendations. In her September pharmacy review for Resident #13, the GDR for Trazadone had not been attempted, and the GDR recommendation was given to the facility again. The Consultant Pharmacist indicated she was unaware why the recommendation signed on 9/10/24 was not completed for Resident #13. She stated her monthly pharmacy recommendations are given to the Director of Nursing who provides them to the providers.

The NP was interviewed via phone on 11/1/24 at 10:16 AM. The NP stated she had been a provider at the facility beginning in early September 2024. She stated there were multiple pharmacy recommendations provided to her from the DON when she began working at the facility. The NP indicated she was not aware the order for the GDR was not entered for Resident #13 after it had been signed on 9/10/24. The NP stated the

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October 2024 pharmacy review asked for a GDR for the medication again, and again agreed to the GDR of Trazadone on 10/19/24. The NP stated her orders for the GDR should have been entered by the unit manager or DON.

The Unit Manager was interviewed on 11/1/24 at 3:43 PM. She stated the providers did give her the pharmacy recommendations after they had been signed by the provider. The Unit Manager said it was her responsibility to ensure all pharmacy recommendations and orders had been entered into resident charts. The Unit Manager stated she always signed and dated each pharmacy recommendation after it was entered into each resident's chart. The pharmacy recommendation for Resident #13 signed by the Nurse Practitioner on 9/10/24 for a gradual dose reduction attempt of Trazadone 50 mg reduced to 25 mg by mouth at hours of sleep (HS) was reviewed by the Unit Manager and was not signed by her to indicate the order had been entered. The Unit Manager stated she overlooked the pharmacy recommendation, and did not enter the order for the GDR.

The Director of Nursing (DON) was interviewed on 11/1/24 at 2:25 PM. She stated the facility had changed providers in September 2024 and there had been some confusion on which pharmacy recommendations the previous providers agreed with at that time. The signed order for GDR should have been entered into Resident #13's chart when it was signed by the NP on 9/10/24.

The Administrator was interviewed on 11/1/24 at 3:33 PM. She stated the Unit Manager overlooked the order for the GDR and the order should have been entered for Resident #13.

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store a staff member's opened drink bottle separate from residents' stored food in 1 of 3 kitchen refrigerators. The facility failed to maintain and clean 1 of 1 milk cooler, 1 of 2 ice machines, and 1 of 1 floor kitchen drains, and 1 of 1 baking sheet storage rack. The facility failed to date an opened nutritional supplement in 1 of 1 nourishment refrigerators. This practice had the potential to affect one-hundred and five (105) residents who resided at the facility. Findings Included 1. On 10/29/24 at 9:13 AM an observation of the reach-in milk cooler was found with an opened	F 812	Criteria 1: On October 29, 2024, the Dietary Manager disposed of the open soda bottle in the reach-in milk cooler. On October 29, 2024, the Dietary Manager disposed of the parchment paper in the reach-in milk cooler. On October 30, 2024, the Dietary Manager removed and disposed of the open, undated bottle of Ensure from the nourishment room refrigerator. On October 30, 2024, the Dietary Manager cleaned the storage rack for the ready-to-use baking sheets, the floor drain cover at the two-compartment sink and the ice machine in the kitchen.	11/11/24

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F 812	Continued From page 17 soda bottle laying on top of stored milk cartons. The morning cook stated on 10/29/24 at 9:15 AM the opened soda bottle belonged to kitchen staff, and she was unsure which staff it belonged to. She stated the drink bottle should not be kept in the cooler. 2. On 10/29/24 at 9:13 AM an observation of the reach-in milk cooler revealed the bottom of the milk cooler contained baking sheets which were covered with parchment paper. Multiple areas of parchment paper on each baking sheet contained dried white substance with a fuzzy greenish to brownish substance. 3. An observation of the inside of the kitchen ice maker on 10/29/24 at 9:17 AM found the white plastic ice shield to be unclean. The bottom of the plastic shield was directly touching the ice in the machine and the plastic shield contained an orange/pink substance that spanned the length of the ice shield. On 10/30/24 a follow-up kitchen observation was made with the District Dietary Manager. The ice machine plastic shield remained unchanged at 11:38 AM on 10/30/24. 4. At 11:40 AM on 10/30/24 the in-floor drain cover for the two-compartment sink was observed to contain a thick layer of slimy white and pinkish/red colored substance covering a large portion of the drain cover. 5. At 12:33 PM on 10/30/24, the observation found the storage rack for ready-to-use baking sheets to contain a thick buildup of yellow and waxy to touch substance directly under the baking	F 812	Criteria 2: On October 31, 2024, an audit was completed by the Dietary Manager of the nourishment room refrigerator to be sure there were no other bottles of Ensure or other type of supplement that had been opened and not dated. There were no new findings. On November 1, 2024, an audit was completed by the Dietary Manager of all facility ice machines to ensure that they were clean and free of mold and/or debris. The audit found that both ice machines were clean. On November 1, 2024, an audit was completed by the Dietary Manager of all kitchen equipment and drainage areas to ensure that they were clean and free of mold and/or debris. Any deficient areas were corrected. Criteria 3: On November 8, 2024, education for all nurses was initiated by administrator/designee that when any house supplement is opened and not completely consumed, it should be returned to the refrigerator with an open date on the container. On November 1, 2024, education was initiated by the Dietary Manager for all dietary staff that equipment, sheet pans, floors and areas that need to be cleaned are to be cleaned immediately even if not included in the cleaning schedule at that moment. Ice machines are to be cleaned monthly and as needed to ensure that this equipment is free of mold and debris. Also, education includes that employees	

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F 812	Continued From page 18 sheets. The District Dietary Manager stated on 10/30/24 at 3:34 PM she had been the temporary Dietary Manager for the kitchen since the end of September 2024. She stated the previous Dietary Manager did not use a cleaning sheet for the kitchen staff to sign off what had been cleaned and she had started a daily cleaning sheet with assignments for kitchen staff. The District Dietary Manager said kitchen staff should not store personal food items in resident areas, the kitchen staff have their own refrigerator for personal items. She said the ice machine was cleaned monthly by the maintenance department and maintenance would clean it in between when notified. Additionally, the District Dietary Manager stated the reach-in milk cooler would be cleaned monthly or when needed. The clean storage racks, the floor drains and reach in cooler were not on a cleaning list and were assigned to be cleaned on weekends and should have been cleaned. 6. The nourishment room refrigerator was observed on 10/30/24 at 4:02 PM with the District Dietary Manager. The refrigerator door contained one small carton of nutritional supplement that was opened without an open date on it. The District Dietary Manager stated during the observation that the nutritional supplement was placed by a nurse without an open date after the refrigerator had been checked for opened and expired items earlier that day. The Maintenance Director was interviewed on 11/1/24 at 3:20 PM. He stated he cleaned the ice machine in the kitchen and nourishment room once monthly regularly and when needed. He	F 812	are not permitted to store their personal drinks in the kitchen coolers. All dietary staff will receive the education regarding the kitchen issues, including agency staff, will have this education prior to working a shift. All staff, including agency staff, will receive education regarding the dating of opened nutritional supplements prior to working a shift. Criteria 4: Beginning on 11/12/24, the administrator/designee will monitor this process by auditing the nourishment room refrigerator 5 x per week for 8 weeks to ensure that no supplements are found partially consumed and without an open date. Beginning on 11/12/24, the Dietary Manager/designee will monitor this process by auditing both ice machines 5 x week for 8 weeks to ensure that the equipment is free of mold and debris. The findings of these audits will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee for 2 months. Audits will continue at the discretion of the QAPI committee. Administrator is responsible for compliance. The date of compliance is 11/11/24.	

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F 812	Continued From page 19 stated he was not aware the kitchen ice machine needed to be cleaned, normally a kitchen staff would let him know or place it on the maintenance log. The Administrator stated on 11/1/24 at 3:30 PM dirty areas of the kitchen should be cleaned regularly and when dirty. She said the items in the nourishment room refrigerator should be dated when opened and disposed of when it expired.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		11/11/24

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but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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F 880	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with staff, the facility failed to follow their infection control policy and procedures regarding Enhanced Barrier Precautions (EBP) during high-contact care activities for a resident with an indwelling catheter (Resident #75). This failure occurred for 2 of 2 nursing staff observed for infection control practices (Nurse Aide #2 and Nurse Aide #3). Findings included: Review of the facility's Enhanced Barrier Precautions (EBP) policy and procedures dated 04/24/24 read in part, "EBP are used as an infection prevention and control intervention to reduce the spread of multidrug- resistant organisms (abbreviated as MDRO and refers to a type of bacteria that are resistant to one or more classes of antibiotics) to residents. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact care activities requiring the use of gown and gloves for EBP include transferring, changing briefs or assisting with toileting and medical device care or use such as urinary catheter." The policy noted EBP should be used until the discontinuation of the indwelling medical device that placed the resident at higher risk. A physician's order dated 05/06/24 revealed in part Resident #75 was on EBP due to an indwelling urinary catheter and history of methicillin-resistant staphylococcus aureus (abbreviated as MRSA and refers to a type of bacteria resistant to several antibiotics).	F 880	Criteria 1: On November 1, 2024, CNA #2 and CNA #3 were educated by the Director of Nursing (DON) on the requirements for Enhanced Barrier Precautions (EBP) including the need to utilize personal protective equipment (PPE) that includes gown and gloves when engaged in high contact resident care activities. Criteria 2: On November 1, 2024, a walking round audit was completed by the DON to identify any additional infractions for EBP. There were no new findings as a result of this audit. Criteria 3: On November 8,2024, education was initiated by the DON/designee for all staff on the requirements for EBP including the need to utilize PPE that includes gown and gloves when engaged in high contact resident care activities. All staff, including agency staff, will have this education prior to working a shift. Criteria 4: Beginning on 11/12/24, the DON/designee will monitor this process by observing 2 resident encounters per day that require EBP. These audits will be done 5 x per week for 8 weeks to ensure that EBP guidance is followed. The findings of these audits will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee for 2 months. Audits will continue at the discretion of the QAPI committee.	

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F 880	Continued From page 22 a. During an observation on 10/29/24 at 11:58 AM, Resident #75 was observed lying on a low bed stating he needed to use the bathroom. EBP signage was posted on the door of Resident #75's room instructing staff to wear a gown and gloves for high-contact resident care activities that included transferring, providing hygiene, changing briefs or assisting with toileting. A cart containing Personal Protective Equipment (PPE) that included gowns, gloves and masks was positioned just outside the door. Nurse Aide (NA) #2 and NA #3 were observed sanitizing their hands and donning gloves prior to entering Resident #75's room and closing the door. At 11:59 AM, when opening the door to Resident #75's room, NA #2 and NA #3 were observed holding on to Resident #75's hands/arms and physically assisting him up out of bed and into his wheelchair. Neither NA #2 nor NA #3 had donned a gown prior to assisting Resident #75 with transferring. During an interview on 10/29/24 at 12:02 AM, NA #3 exited Resident #75's room and walked to the linen cart located in the hall to gather supplies. NA #3 voiced knowledge of EBP but stated she had not noticed the EBP sign posted on Resident #75's door. NA #3 confirmed she had assisted NA #2 with transferring Resident #75 up out of bed and did not don a gown as instructed on the EBP signage prior to preforming high-contact resident care. NA #3 stated she was only trying to help and should have donned a gown in addition to gloves. b. During an observation and interview on 10/29/24 at 12:04 PM, upon knocking on and opening the door of Resident #75's room,	F 880	Administrator is responsible for compliance. The date of compliance is 11/11/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

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F 880	Continued From page 23	F 880		

Resident #75 was in the bathroom and NA #2 was observed standing by the bathroom door unfolding a brief. NA #2 was not wearing a gown. NA #2 looked into the bathroom and told Resident #75 she would be right back and then walked toward the bedroom door. NA #2 confirmed the EBP signage was posted on Resident #75's door and stated that she was unaware Resident #75 was still on EBP. NA #2 stated Resident #75 was on the toilet and she was assisting him with care. NA #2 verified she did not don a gown prior to assisting Resident #75 up out of bed and to the bathroom. NA #2 expressed she always wore gloves when providing high-contact resident care activities and should have also donned a gown according to the EBP signage.

During an interview on 11/01/24 at 9:33 AM, the Director of Nursing (DON)/Infection Preventionist confirmed Resident #75 was on EBP due to having an indwelling urinary catheter. The DON explained if nursing staff were only providing verbal cueing to residents on EBP, then a gown was not necessary. However, if staff were actually touching the resident and/or providing physical assistance during high-contact resident care, they were expected to don the appropriate PPE.

During an interview on 11/0124 at 3:42 PM, the Administrator stated staff had received education related to EBP and the posted signage was pretty clear as to what nursing staff were required to do. The Administrator stated both NA #2 and NA #3 should have followed the EBP instructions regarding PPE use when providing Resident #75's care.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345312	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 11/1/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	**1870 PISGAH DRIVE HENDERSONVILLE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 568	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Responsible Party (RP) and staff the facility failed to provide written quarterly statements for 1 of 3 residents reviewed personal funds (Resident #64). The findings included: Resident #64 was admitted to the facility on 01/23/24 with diagnoses including dementia. The quarterly Minimum Data Set dated 09/02/24 assessed Resident #64 as having severely impaired cognition. A review of the medical records revealed Resident #64 had an RP designated as the emergency contact. During an interview on 11/01/24 at 1:32 PM the RP revealed money for Resident #64 was held in an account by the facility. The RP revealed she provided her mailing address and received a letter informing her the quarterly statements would be mailed to her. The RP revealed she had not received all the written quarterly statements since Resident #64's admission to the facility on 01/23/24. The RP revealed the facility did call her to discuss the amount of money in the account and what items she wanted them to purchase for Resident #64 but could not recall the exact dates. An interview was conducted on 11/01/24 at 2:26 PM with the Business Office Manager. The Business Office Manager confirmed she was the person responsible for sending the written quarterly statements to the resident or their designated RP. The Business Office Manager revealed the process was she received a reminder quarterly statements were due and entered the information into the computer system she used to print the quarterly statements. A copy of the quarterly statements was kept for the facility records and sent to the Regional Office. The Business Office Manager indicated she was not aware of the regulatory guidance that she was required to provide the resident or RP a written quarterly statement. The Business Office Manager confirmed the RP of Resident #64 did not receive written statements for 6/2024 and 9/2024 and provided a copy of those quarterly statements that included notes to indicate it was reviewed with the RP over the phone. The Business Office Manager stated it was her practice as long the resident or RP knew the amount of money

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345312	A. BUILDING: _____ B. WING _____	11/1/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 568	Continued From Page 1

in their account it was okay not to mail or email a copy of the written quarterly statement and she had not been informed otherwise. The Business Office Manager revealed she spoke to either the resident or their designated RP to review each quarterly statement and if verbally discussed no written quarterly statement was provided unless requested.

During an interview on 11/01/24 at 3:47 PM the Administrator stated she knew the regulatory guidance was to provide a written quarterly statement and expected the BOM to follow the regulation.