| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345312 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 01/16/2026 |
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| **The Greens at Hendersonville** | **1870 Pisgah Drive , Hendersonville, North Carolina, 28791** |

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| E0000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 01/12/26 through 01/16/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1E05A9-H1. | E0000 | | 02/06/2026 |
| F0000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 01/12/26 through 01/16/26. Event ID #1E05A9-H1.<br><br>The following intakes were investigated: 771451, 771454, 2637265, 2656301, 2683368, 2712580, and 2714535. Twelve (12) of the twelve (12) complaint allegations did not result in deficiency. | F0000 | | 02/06/2026 |
| F0641<br>SS = D | Accuracy of Assessments<br><br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br><br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br><br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br><br>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>§483.20(j) Penalty for Falsification.<br><br>§483.20(j)(1) Under Medicare and Medicaid, an | F0641 | Hendersonville POC F641<br><br>F 641<br><br>1. On 1/20/26 Minimum Data Set (MDS) Assessment Nurse corrected and resubmitted assessment for Residents #4 and #8.<br><br>2. On 2/1/26, the MDS Assessment Nurses audited the last completed MDS for all current residents to ensure coding accuracy of section K0300 related to weight loss. No further errors identified.<br><br>3. The Corporate Resident Assessment Instrument (RAI), educator completed education with Dietary Tech and Registered Dietician on 1/19/26 - 1/20/26 on accurate coding of Section K0300 per the RAI manual.<br><br>4. The MDS Assessment Nurse or designee will audit section K0300 of the MDS on 3 residents weekly for accuracy of weight loss coding for 8 weeks to ensure ongoing compliance with weight loss coding accuracy. Results of these audits will be brought before the Quality Assurance and Performance Improvement (Qapi), Committee monthly with the QAPI Committee responsible for ongoing compliance. | 02/04/2026 |

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 reverse for further 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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| F0641 SS = D | Continued from page 1<br>individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of weight loss for 2 of 4 residents whose MDS assessments were reviewed (Resident #8 and Resident #4).<br><br>Findings included:<br><br>1. Resident #8 was admitted to the facility 06/22/23 with a diagnosis including malnutrition.<br><br>Review of Resident #8's active physician orders revealed a diet order dated 10/03/23 for a regular diet with fortified foods. Further review revealed there were no physician orders for a weight-loss regimen.<br><br>A list of Resident #8's weights were as follows:<br><br>08/07/25 199 pounds<br><br>09/17/25 198.5 pounds<br><br>10/16/25 196.4 pounds<br><br>11/15/15 157.2 pounds<br><br>12/12/25 158 pounds<br><br>A review of a Registered Dietitian (RD) note dated 12/02/25 indicated Resident #8 consumed between 1% and 75% of meals, received fortified foods (foods enhanced with additional vitamins and minerals), and required increased protein intake to support wound healing. The RD also documented concerns regarding the accuracy of the recorded weight on 11/15/25.<br><br>A review of Resident #8's nutrition care plan, last updated on 12/06/25, indicated the resident had an | F0641 | Continued from page 1<br>5. Date of Compliance: 2/2/2026. The Administrator is responsible for the plan of correction. | |

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| F0641 SS = D | Continued from page 2<br>actual or potential nutritional concern associated with adult failure to thrive (characterized by unintentional weight loss, decreased appetite, and poor nutrition), dementia, and gastroesophageal reflux disease (GERD). The care plan interventions included monitoring for dysphagia (difficulty swallowing), observing for signs of malnutrition such as muscle wasting or significant weight loss, and ensuring the prescribed diet was provided as ordered.<br><br>The quarterly MDS assessment dated 12/30/25 reflected that Resident #8 had weight loss and was on a physician-prescribed weight loss regimen.<br><br>During a telephone interview on 01/14/26 at 10:21 AM, the Registered Dietitian (RD) reported that the Dietary Technician assisted with completing residents' quarterly MDS assessments and was trained to complete Section K, which addresses weight gain and weight loss. The RD confirmed that the Dietary Technician coded Section K for Resident #8's quarterly MDS assessment dated 12/30/25. The RD further stated that Resident #8's care plan did not indicate any desire for weight loss, nor was the resident prescribed weight loss medication. Therefore, the RD was unsure why the MDS was coded as reflecting a physician-prescribed weight loss regimen.<br><br>The Dietary Technician was not available for interview during the investigation.<br><br>During an interview on 01/16/26 at 10:54 AM, the MDS Nurse stated that she did not complete Section K of Resident #8's quarterly MDS assessment and was unsure why the Dietary Technician coded the resident's weight loss as physician prescribed.<br><br>During an interview on 01/16/26 at 11:24 AM, the Administrator stated that MDS assessments should be coded accurately. He further explained that he would expect the Dietary Technician to inform the Registered Dietitian (RD) if Resident #8's weight loss was coded as a physician-prescribed weight loss regimen, and then both should have notified the MDS Nurse for clarification.<br><br>2. Resident #4 was admitted to the facility on 12/13/24. Her cumulative diagnoses included dementia, chronic kidney disease and diabetes.<br><br>A physician's order dated 05/09/25 revealed Resident #4 | F0641 | | |

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| F0641 SS = D | Continued from page 3<br>was to receive torsemide (diuretic) 10 milligrams (mg) once daily for diuretic (used to increase urine production to remove excess salt and water from the body).<br><br>Resident #4's weights were documented as follows:<br><br>-07/14/25 136 pounds (lbs.)<br><br>-08/07/25 136 lbs.<br><br>-09/17/25 137 lbs.<br><br>-10/16/25 140 lbs.<br><br>-11/28/25 124 lbs.<br><br>-12/08/25 117 lbs.<br><br>Review of Resident #4's active physician orders revealed a diet order dated 11/14/25 for a regular diet with mechanical soft texture and regular consistency. Further review revealed there were no physician orders for a weight-loss regimen.<br><br>Review of Resident #4's December 2025 Medication Administration Record revealed torsemide 10 mg daily was initialed by nursing staff as administered per physician orders.<br><br>The quarterly Minimum Data Set (MDS) dated 12/08/25 revealed Resident #4 had no swallowing disorder, weighed 117 lbs. and received diuretic medication. The MDS further noted Resident #4 had a significant weight loss of 5% or more in the last month or loss of 10% or more in the last six months and was on a physician-prescribed weight-loss regimen.<br><br>A Dietary Technician progress note dated 12/08/25 revealed Resident #4 had a significant weight loss trend at 1, 3, 6 months and weight changes/fluid shift were likely related to diuretic treatment (torsemide), chronic kidney disease and history of bilateral lower extremities edema. The Dietary Technician recommended continuing to monitor.<br><br>The Dietary Technician was unable to be interviewed.<br><br>During an interview on 01/16/26 at 10:55 AM, the MDS Nurse stated she was not sure why the Dietary Technician coded Resident #4's weight loss as physician-prescribed. The MDS Nurse explained for a resident taking diuretic medication, the only time she would code weight loss on the MDS assessment as | F0641 | | |

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| F0641 SS = D | Continued from page 4<br>physician-prescribed was if the medication was intentionally being used for weight loss.<br><br>During a phone interview on 01/14/26 at 10:11 AM, the Registered Dietician (RD) revealed the Dietary Technician assisted with assessing residents quarterly and had been trained to complete MDS assessments. The RD stated the Dietary Technician likely got the concept that diuretic medication use was considered a weight loss regimen since Resident #4 was losing weight due to a physician-prescribed medication. The RD explained even when diuretic medication was prescribed for fluid buildup it could cause weight loss. The RD stated she would not have coded diuretic medication use a physician-prescribed weight loss regimen on the MDS assessment without verifying the medication was prescribed with the intention for planned weight loss.<br><br>During an interview on 01/16/26 at 11:24 AM, the Administrator stated he would expect for MDS assessments to be coded accurately. The Administrator stated he would expect for the Dietary Technician to notify the RD that Resident #4's weight loss was coded as a physician-prescribed weight loss regimen and then they should have notified the MDS Nurse for her to clarify. | F0641 | | |
| F0644 SS = D | Coordination of PASARR and Assessments<br><br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br><br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br><br>This REQUIREMENT is NOT MET as evidenced by: | F0644 | F644 – Coordination of PASRR and Assessments<br><br>Criteria 1<br><br>On 1/20/26, Resident #99, Resident #12, and Resident #101 were reviewed by the Director of Social Services and level II screening requests were completed for each resident.<br><br>Criteria 2<br><br>All residents with a diagnosis for serious mental illness have the potential to be affected by the deficient practice. The Director of Social Services will complete an audit of all resident diagnoses on 2/1/26, to ensure that any resident with an existing or new diagnosis for mental illness will have a PASRR level II screening request made on or before 2/1/26.<br><br>Criteria 3<br><br>On 1/20/26, the facility administrator educated team members who participate in the PASRR request process for mental health diagnoses: social services director, minimum data set coordinators, and director of nursing. The education advised on the necessity for timely | 02/04/2026 |

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| F0644<br>SS = D | Continued from page 5<br>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 residents previously determined to have a Level I status for a PASRR after a new serious mental disorder was identified for 3 of 3 residents reviewed for PASRR (Resident #99, Resident #12, Resident #101).<br><br>The findings included:<br><br>1. Review of Resident #99's medical record revealed a PASRR Determination Notification letter dated 11/08/13 which reported Resident #99 had a Level I PASRR determination with no expiration date, and “no further PASRR screening is required unless a significant change occurs with the individual’s status which suggested a diagnosis of mental illness.”<br><br>Resident #99 was admitted to the facility on 1/19/24.<br><br>Review of Resident #99’s medical record revealed her current active diagnoses included dementia, generalized anxiety disorder (diagnosed on 1/23/24), delusional disorder (diagnosed on 10/23/24), and hallucinations (diagnosed on 10/23/24).<br><br>Review of the provider note dated 1/02/26 revealed Resident #99 was followed by psychiatry for anxiety and listed active diagnoses of delusional disorder and hallucinations.<br><br>Review of the medical record revealed no evidence a request was submitted for a Level II PASRR evaluation.<br><br>An interview conducted on 1/14/26 at 11:03 AM with the Social Worker (SW) revealed she was aware that a Level II PASRR evaluation submission should be completed for residents with a mental health diagnosis upon their admission, when they received a new mental health diagnosis, or had a significant change in status. She stated she did not have a reason as to why Resident #99 did not have a request for a Level II PASRR evaluation completed. After reviewing Resident #99’s mental health diagnoses, the SW stated a Level II PASRR evaluation should have been requested.<br><br>During an interview on 1/16/26 at 11:47 AM with the Administrator, he indicated that the SW was responsible for submitting a request for a Level II PASRR evaluation. He stated due to Resident #99’s new mental health diagnoses on 10/23/24 a request for a Level II PASRR evaluation should have been submitted.<br><br>2. A PASRR Determination Notification letter dated | F0644 | Continued from page 5<br>notification to facility social services director of mental health diagnoses and required requests for PASRR reviews upon admission, readmission, or if a new diagnosis is given. Newly hired team members who will participate in the PASRR review process will be educated on this process by the administrator or social service director upon hire.<br><br>Criteria 4<br><br>The social services director will audit 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks to ensure requests for PASRR reviews have been submitted based on existing qualifying diagnosis or newly added diagnoses. The facility administrator will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.<br><br>Date of compliance is 2/2/2026. The Administrator is responsible for the plan of correction. | |

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| F0644 SS = D | Continued from page 6<br>03/22/24 revealed Resident #12 had a Level I PASRR with no expiration date that indicated “no further PASRR screening is required unless a significant change occurs with the individual’s status which suggested a diagnosis of mental illness or if present, suggests a change in treatment needs for those conditions.”<br><br>Resident #12 was admitted to the facility on 03/22/24 with diagnoses that included unspecified psychosis and anxiety disorder.<br><br>A Hospice Registered Nurse (RN) progress note dated 11/14/24 revealed facility staff reported Resident #12 had shown increased agitation and aggression the past week. The Hospice RN notified the attending hospice provider and received orders to initiate olanzapine (antipsychotic) 5 milligrams (mg) twice a day.<br><br>Review of Resident #12’s list of cumulative diagnoses revealed a new mental health diagnosis of delusional disorder was added on 11/20/24.<br><br>The facility was unable to provide documentation that a request was submitted for a Level II PASRR evaluation for Resident #12 following the new mental health diagnosis of delusional disorder.<br><br>The annual Minimum Data Set (MDS) assessment dated 03/30/25 revealed Resident #12 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability.<br>Her active diagnoses included anxiety disorder and psychotic disorder (other than schizophrenia). She received antipsychotic, antidepressant and anticonvulsant medications during the MDS assessment period.<br><br>A Nurse Practitioner (NP) progress note dated 12/22/25 revealed Resident #12 had diagnoses of delusional disorder, unspecified psychosis and anxiety disorder. Resident #12 received olanzapine 2.5 milligrams (mg) once daily and quetiapine (antipsychotic) 50 mg twice daily for unspecified psychosis. The NP noted Resident #12 had no acute psychiatric symptoms and her mental status appeared stable related to delusional disorders with the plan to continue current management.<br><br>During an interview on 01/15/26 at 11:03 AM, the Social Worker (SW) revealed she was the person responsible for submitting requests for a Level II PASRR evaluation.<br>The SW stated she was aware that Level II PASRR evaluations should be completed for residents with a mental health diagnosis upon their admission, when they received a new mental health diagnosis, or had a | F0644 | | |

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| F0644 SS = D | Continued from page 7<br>significant change in status. The SW stated the MDS Nurse notified her of significant changes but currently there was no process in place to notify her when a resident received a new mental health diagnosis. She explained in September 2025, the Corporate Consultant gave her a list of residents with mental health diagnoses for her to submit requests for Level II PASRR evaluations. She stated she was currently working down the list but it was taking some time due to all of her other job responsibilities. The SW verified Resident #12 was on the list to request a Level II PASRR but one had not been submitted until 01/14/26. The SW verified a Level II PASRR evaluation should have been requested following Resident #12's new mental health diagnosis of delusional disorder on 11/20/24.<br><br>During an interview on 01/16/26 at 11:47 AM, the Administrator confirmed the SW was the person responsible for submitting a request for a Level II PASRR evaluation. He verified that due to Resident #12's new mental health diagnoses of delusional disorder on 11/20/24 a request for a Level II PASRR evaluation should have been submitted. The Administrator explained in September 2025, they had identified an issue with PASRR, the SW was given a list of residents with mental health diagnoses to submit requests for a Level II PASRR evaluation and she was currently making progress. The Administrator stated the SW had a lot of "irons on her plate" and he planned to work with her to see what job responsibilities could be reassigned to other staff to help with her work load so she could continue working on getting the necessary referrals for PASRR evaluations submitted.<br><br>3. Review of Resident # 101's medical record revealed a PASRR Level I was completed on 11/05/2016 prior to admission with a recommendation to resubmit paperwork for a PASARR Level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition.<br><br>Resident #101 was admitted to the facility on 11/07/2016.<br><br>Review of the Psychiatric Nurse Practitioner's 08/27/2025 progress note revealed Resident #101 was taking Escitalopram (an antidepressant) 5mg daily (after gradual dose reduction) and Lorazepam (antianxiety) 0.5mg twice daily. A diagnosis of bipolar disorder was added at this time with no new orders added.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated 12/29/2025 revealed Resident #101 was | F0644 | | |

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| F0644 SS = D | Continued from page 8<br>coded for mental health diagnoses including anxiety disorder, depression, and bipolar disorder.<br><br>Review of the medical record revealed there was no documented evidence that a request was submitted for a Level II PASRR evaluation.<br><br>During an interview on 01/16/2026 at 11:11 AM the MDS Nurse communicated a new mental health diagnosis would come from psychiatric progress notes. The MDS Nurse stated if the MDS Nurse enters a new mental health diagnosis they should notify the Social Worker. The MDS Nurse stated the current process was to email the Social Worker of a new mental health diagnosis.<br><br>During an interview on 01/15/2026 at 11:03 AM with the Social Worker, she stated when a resident has a new mental health diagnosis, she would be the person responsible for requesting a Level II PASRR evaluation. The Social Worker revealed the MDS Nurse would inform her of a significant change. The Social Worker stated there was no system in place to notify her of new mental health diagnosis, that she was only notified of significant changes.<br><br>During an interview with the Administrator on 01/16/2026 at 11:47 AM, he stated that anytime psychiatry communicated a diagnosis change the Social Worker should be informed. The Administrator stated it was the Social Worker's responsibility to submit requests for PASRR evaluations and the Social Worker attends morning meetings where all new orders and new diagnoses were discussed. | F0644 | | |