STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Weaverville	**78 Weaver Boulevard , Weaverville, North Carolina, 28787**

(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
F0000	INITIAL COMMENTS A complaint survey was conducted from 6/09/26 through 6/10/26. Additional information was gathered through 6/12/26, therefore, the exit date was changed to 6/12/26. The following intake was investigated 3036498. 1 of 1 complaint allegation did not result in deficiency. Event ID: 23554D-H1.	F0000		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer.	F0628	Criteria 1: Resident #1 is no longer at facility. Criteria 2: All residents discharging to a lower level of care are at risk for the alleged deficit practice. On 6/09/26, an audit of all discharges to a lower level of care in the past 90 days was completed by Director of Nursing to ensure that FL-2's had the appropriate medications and allergy list. Any discrepancies found were addressed with the facility that received the resident, and a medication and allergy list that was accurate at the time of discharge was faxed to the receiving facility if the resident was still residing at facility. Criteria 3: On 6/09/26, Social worker, Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager, Medical Director (MD), and Nurse Practitioner (NP) were educated by the administrator on the process of completing FL-2s that are sent to an alternate facility at discharge. The education consisted of the following verification requirements:	06/17/2026

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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F0628 SS = D	Continued from page 1 Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F0628	Continued from page 1 Medication Verification – Two-Nurse Process · Medications listed on the FL2 form must be reviewed for accuracy. · Two nurses must verify accuracy by comparing the FL2 medication list to Point Click Care (PCC) orders. · Printed PCC orders must be attached to the FL2 form. · Both nurses must sign the printed PCC orders and FL2 form to confirm accuracy. Medication Verification – Provider Signature Social worker will instruct when an FL-2 is needed; nurse manager will initiate the process and deliver to Medical Director/Nurse Practitioner when nursing verification has been completed. · When the FL2 form is completed and signed by the nurse managers, the MD or NP will then verify orders and sign indicating medication accuracy. · The provider must ensure medications listed match PCC discharge orders. Allergy Verification – Two-Nurse Process · Allergies listed on the FL2 form must be reviewed for accuracy. · Two nurses must verify accuracy by comparing the FL2 allergy list to allergies documented in PCC. · Two nurse signatures will verify accuracy. This training will be provided by the Administrator for any newly hired or contracted staff who work in	06/17/2026

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F0628 SS = D	Continued from page 2 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F0628	Continued from page 2 social services, Director of Nursing, Assistant Director of nursing, or Unit Manager roles and providers who would potentially be signing FL-2s prior to working in the facility. Criteria 4: Director of Nursing/designee will audit all discharges to a lower level of care weekly times 8 weeks to ensure FL-2s contain accurate medications and allergies. The administrator will review monitoring results and report to Quality Assurance Process Improvement (QAPI) meetings monthly to ensure substantial compliance has been met. Audits will continue at the discretion of the QAPI committee. Date of compliance is 6/10/26	06/17/2026

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F0628 SS = D	Continued from page 3 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by:	F0628		06/17/2026

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F0628 SS = D	Continued from page 4 Based on record review, and staff, Primary Care Physician (PCP), facility Physician, Nurse Practitioner (NP), assisted living Director of Nursing, and Consultant Pharmacist interviews, the facility failed to provide an accurate medication list on an FL-2 to an assisted living facility for a resident who was discharged home from the facility while waiting on assisted living placement. The allergies listed were also incorrect. This deficient practice occurred for 1 of 3 residents reviewed for discharge (Resident #1). Findings included: Resident #1 was admitted to the facility on 3/10/26 with diagnoses which included an encounter for orthopedic aftercare following surgical amputation of right second toe, Alzheimer's dementia, essential hypertension, and hyperlipidemia. Resident #1's discharge instructions dated 3/18/26 revealed he was discharged home on 3/18/26 with his correct current medication summary list. This list of medications was signed by the Responsible Party (RP), dated 3/18/26 and included the following medications: Acetaminophen 325 milligrams (mg) 2 tablets by mouth three times a day for pain Donepezil 10 mg 1 tablet by mouth at bedtime for dementia Escitalopram 10 mg 1 tablet by mouth one time a day for mood symptoms Famotidine 20 mg 1 tablet by mouth one time a day for stomach acid Fenofibrate 145 mg 1 tablet by mouth one time a day for cholesterol Losartan 50 mg 1 tablet by mouth in the morning for hypertension Melatonin 3 mg 1 tablet by mouth every 24 hours as needed for insomnia for 14 days Memantine 10 mg 1 tablet by mouth two times a day for dementia Nystatin powder apply to groin and scrotum topically every day and evening for yeast for 14 days	F0628		06/17/2026

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F0628 SS = D	Continued from page 5 Resident allergies were listed as hydrochlorothiazide and tricor An FL-2 (The Adult Care Home FL2 Form is a document signed by a physician or nurse practitioner which contained medical diagnoses, medications, functional limitations, and care needs required to qualify for Medicaid coverage or facility admission) with Resident #1's name and date of birth was completed by the facility Social Worker (SW), signed by the NP on 3/18/26, and emailed to the assisted living facility by the SW. The FL-2 with Resident #1's name and date of birth on 3/18/26 included the following information: Anastrozole 1 mg 1 tablet by mouth one time a day (female hormone medication used to treat/prevent breast cancer in postmenopausal women) Apixaban 5 mg 1 tablet by mouth two times a day (blood thinner) Aspirin 81 mg 1 tablet by mouth one time a day (heart attack prevention) Atorvastatin 80 mg 1 tablet by mouth at bedtime (cholesterol inhibitor) Bupropion 300 mg 1 tablet by mouth one time a day (antidepressant/mood stabilizer) Diazepam 2 mg 1 tablet by mouth two times a day (antianxiety) Furosemide 40 mg 1 tablet by mouth one time a day (diuretic) Metoprolol 50 mg 2 tablets by mouth one time a day (blood pressure) Sacubitril-Valsartan 24-26 mg 1 tablet by mouth two times a day (chronic heart failure) Tramadol 50 mg 1 tablet by mouth every 4 hours as needed (opioid pain) Acetaminophen 500 mg 1 tablet by mouth two times a day (pain) Vitamin B12 500 micrograms (mcg) by mouth one time a day (supplement)	F0628		06/17/2026

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F0628 SS = D	Continued from page 6 Vitamin D3 25 mcg 1 tablet by mouth one time a day (supplement) The block title additional information had handwritten hydrochlorothiazide, flagyl per medical review-attached and signed. The attached medication order summary was for Resident #2, not Resident #1. An interview with the Social Worker (SW) on 6/09/26 at 9:05AM revealed Resident #1 was on the waiting list for an assisted living facility prior to admission to the facility. He was admitted to the facility for short term rehabilitation after surgical amputation of right second toe. He was discharged home from the facility on 3/18/26 before his assisted living placement was available. During the discharge process, the RP requested the necessary paperwork for the Resident #1's assisted living admission be sent to the assisted living facility. The SW stated she prepared the FL-2 which included the resident's medications and asked the NP to sign it. She stated she had mistakenly copied the medications from Resident #2's electronic health record onto Resident #1's FL-2. The SW also stated she had emailed the completed and signed FL-2 with the incorrect medication list to the assisted living facility. The SW indicated the assisted living Sales Director, contacted SW and requested additional information which included allergies which the SW handwrote the allergies under the block additional information on the FL-2 and emailed it again to the assisted living facility. The SW stated she typically completed the resident identification information on the FL-2 and nursing completed the medication information which the physician reviewed and signed. She stated she was trying to expedite the process and help by filling out the medications on the FL-2. An interview with Nurse #1 on 6/09/26 at 10:05 AM revealed she had discharged Resident #1. She stated she reviewed his discharge information with his RP and provided a medication list utilizing the facility discharge forms. She stated she had not seen an FL-2 and had not talked to the assisted living facility. An interview with the Nurse Practitioner (NP) on 6/09/26 at 10:25 AM confirmed it was her signature on the FL-2 dated 3/18/26 for Resident #1. She stated the physician usually reviewed and signed the FL-2 and she had not reviewed or signed many FL-2s in the past. She did not specifically remember	F0628		06/17/2026

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F0628 SS = D	Continued from page 7 signing Resident #1's FL-2 and did not know why she had signed it but believed she did not review it as thoroughly as she should have. She stated the Anastrozole which is a breast cancer medication typically given only to females would have been a red flag during a review of the medication list. A telephone interview with Resident #1's Primary Care Physician (PCP) on 6/09/26 at 12:19 PM revealed she was familiar with Resident #1. She stated she had not seen the resident in quite a while but medication concerns were brought to her attention after someone in her office reached out to the RP to check on the resident's status. The RP reported concerns about medication changes and the resident's condition which the PCP office staff relayed to the PCP. The PCP contacted the assisted living facility Director of Nursing (DON) to discuss Resident #1 condition, and they discovered he was taking the wrong medications. Resident #1's medications were corrected on 5/15/26. The PCP stated there were 2 issues with Resident #1's medication changes. He was started on all new medications at one time. She stated the blood thinner was not indicated for any of his medical conditions and that changes in his blood pressure medications could negatively impact his cardiovascular system. She also stated that he had been very stable for quite some time on his regimen of medications which included 2 dementia medications, Donepezil and Memantine, and a mood stabilizer, Escitalopram. She believed that abruptly stopping these medications was detrimental to him and could adversely affect his dementia and depression. Some of the changes could include increased confusion, depression, and loss of appetite. She stated that any sort of medication changes tended to affect a dementia resident more than a normal person. The PCP stated she had not personally seen the resident but had been told he was not doing well. A telephone interview with the facility Physician on 6/09/26 at 1:04 PM revealed she did not remember anything about Resident #1's FL-2. She stated she could not answer about his medication consequences related to the abrupt stop of current medications and being given different medications. She stated she could only assume he was having difficulties with such a "big list of wrong things" but could not speak about what happened. A telephone interview with the assisted living	F0628		06/17/2026

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F0628 SS = D	Continued from page 8 Director of Nursing (DON) on 6/09/26 at 12:32 PM revealed Resident #1 had been admitted to the facility on 4/06/26. She stated the assisted living facility had received an FL-2 from his prior nursing home and had used it for his medications. She had not reached out to the nursing home and was unaware of any medication concerns until his PCP reached out to her on 5/15/26. She stated the PCP had noted medication discrepancies and these medications were immediately stopped and he was restarted on his correct medications. She stated she believed he had received the wrong medications for about 4 weeks. She was unable to say if he had any adverse effects except, she was aware that he had been very sleepy. An interview with the Consultant Pharmacist on 6/09/26 at 2:00 PM revealed that medications were very specific to a person and people were affected differently. She stated that no one should take medications they do not need. She reviewed Resident #1's medications and Resident #2's and stated that she felt there were no 'huge' cumulative changes. She did note that Diazepam required a taper and careful monitoring during discontinuation. Anastrozole was a breast cancer medication which affects estrogen in females and would not have targeted his chemical pathways. She also noted that Apixaban had a lower bleeding risk than some blood thinners. An interview with the Consultant Pharmacist Supervisor on 6/12/26 at 1:29 PM revealed he believed the abrupt discontinuation of the dementia medications, Donepezil and Memantine, may increase Resident #1's agitation if he had any, but noted the resident did not have behaviors listed on his diagnoses list. He stated the Escitalopram and Bupropion were both antidepressants and switching would likely cause no significant adverse effects. He stated that Resident #1 did not have a medical diagnosis for Apixaban, so it might cause extra bruising. The Atorvastatin and the Fenofibrate might cause an abnormal lab value but nothing clinically significant. The addition of Furosemide had the potential to increase Resident #1's thirst or electrolyte abnormality. Resident #1 was supposed to be on Losartan for high blood pressure, and this was switched to Metoprolol and Sacubitril-Valsartan which had the potential to lower his heart rate but all were blood pressure medications. He was unable to speak about the Tramadol as this was ordered as needed and did not know if Resident #1 received this medication. Diazepam could have caused	F0628		06/17/2026

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F0628 SS = D	Continued from page 9 increased lethargy and confusion. Anastrozole likely did not have any significant adverse effects since Resident #1 was a male. The Consultant Pharmacist Supervisor stated that a Physician should assess Resident #1, but it would likely be very difficult to discern any adverse effects from the medication errors. An interview with the Administrator on 6/09/26 at 4:18 PM revealed she was unaware there had been an error in the FL-2 for Resident #1 until the surveyor notified them and believed this was a human error.	F0628		06/17/2026