STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345123	A. BUILDING _____ B. WING _____	01/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted 01/21/25 through 01/24/25. The facility was found in compliance with the requiurement CFR 483.73, Emergency Preparedness. Event ID# 2U2M11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted on 01/21/25 through 01/24/25. Event ID# 2U2M11.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to assess the ability of a resident to self-administer medications and supplements for 1 of 1 resident with medication observed in the room (Resident #3). Findings included: Resident #3 was admitted to the facility 12/12/24 with diagnoses including hypertension (high blood pressure) and hypercholesterolemia (high cholesterol). Review of Resident #3's medical record revealed no documentation that Resident #3 was assessed for self-administration of medications or supplements.	F 554	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; For the resident who was observed with a medicine cup in their room, it was removed by the nurse upon being found left in the room by surveyor. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Upon the Director of Nursing being notified of medicine cup in the room a message was sent to all staff who administer medications. the message	2/18/25

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

Electronically Signed | 02/13/2025

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F 554	Continued From page 1 The admission Minimum Data Set (MDS) assessment dated 12/19/24 revealed Resident #3 was cognitively intact. Review of Resident #3's physician orders revealed the following: CoQ10 (an antioxidant which protects cells from damage) 400 milligram (mg) daily ordered 12/20/24 Ezetimibe (a medication for high cholesterol) 10 mg once a day ordered 12/13/24 Fish Oil 1200 mg once a day ordered 12/20/24 Flax Seed Oil (a supplement that may decrease inflammation) 100 mg once a day ordered 12/20/24 Garlic Oil 1000 mg once a day ordered 12/20/24 Escitalopram (an antidepressant) 5 mg once a day ordered 12/13/24 Lisinopril 5 mg once a day hold for systolic blood pressure <120 ordered 12/17/24 Psyllium Husk (laxative) 2 capsules once a day ordered 12/20/24 Turmeric (a supplement that may decrease inflammation) 1000 mg once a day ordered 12/20/24 Zinc 30 mg once a day ordered 12/20/24 An observation of Resident #3's overbed table on 01/21/25 at 11:08 AM revealed a cup of medication with approximately nine pills sitting on the table. An interview with Resident #3 at the same date and time revealed she wasn't sure what most of the pills were, but she thought several of them were supplements. She stated she didn't want to take her medications when the nurse brought them to her the morning of 01/21/25 and asked the nurse to leave the	F 554	stated that leaving medication cups in the room is not acceptable except when assessment has been completed to determine if resident can self-administer medication. Director of Nursing also asked Pharmacy to do medication pass with staff and observe for any medication cups left in room and pharmacy reported back that they did not see any. Pharmacy completed room observation for medicine cups at bedside on 1/31/2025. Deficient practice not observed again during annual survey. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Administrative Nursing team will in-service the staff who administer medications regarding medication left at bedside and when it is and is not appropriate. Inservicing of staff who administer medications will be completed by 2/17/2025. Staff Development Coordinator will also include same in-service education given to current staff to any new hires who will be administering medication. This will completed on-going for any new hires moving forward. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrative Nursing team will round resident rooms to check for medication cups on the following	

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F 554	Continued From page 2 medications on her table and she would take them later. Resident #3 stated nurses frequently left medications on her table at her request. An interview with Nurse #2 on 01/21/25 at 11:24 AM revealed when she brought Resident #3 her medications and supplements around 8:30 AM the morning of 01/21/25, Resident #3 did not want to take the medication because she hadn't eaten yet. She stated Resident #3 asked her to leave the medications on her overbed table and told her she would take them later. Nurse #2 stated she should have removed Resident #3's medication from the room instead of leaving it on the overbed table when Resident #3 informed her she did not want to take the medication. She confirmed the medications and supplements in the cup were CoQ 10, Escitalopram, Ezetimibe, Fish Oil, Garlic Oil, Turmeric, Zinc, and Lisinopril. Nurse #2 stated Resident #3's blood pressure was 130/77 the morning of 01/21/25. In an interview with the Director of Nursing (DON) on 01/24/25 at 12:24 PM she confirmed there were no residents with physician orders to self-administer oral medication or supplements. She explained if a resident wanted to self-administer medication, the physician was notified of the request, and she completed an assessment to see if the resident was safe to administer their medication. The DON stated if the resident was assessed as being safe to administer their medication, the interdisciplinary team was notified, and a physician order was obtained. She stated the medications were kept in the nightstand in a locked drawer. The DON stated unless a resident had an order to self-administer medications, the nurse should observe the resident taking medication or remove	F 554	schedule: 5x a week for three weeks. 3x a week for three weeks. 1x a week for 3 weeks and randomly thereafter. Results of the findings will be recorded on sheets created for administrative nurses to check off compliance. Results of administrative nursing rounds will be reported to QAPI for review. Rounds will start after Inservice completion on 2/17/2025 Anticipated completion of corrective action will be done as followed: In-service completion date 2/17/2025 Administrative nursing rounds completion date: 4/18/2025	

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F 554	Continued From page 3 medication from the room and discard it. An interview with the Administrator on 01/24/25 at 1:01 PM revealed he expected nursing staff to follow facility policy for self-administration of medication or stay with the resident during medication administration.	F 554		
F 812 SS=E	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 remove food items past the date indicated for use in the walk-in refrigerator. This practice occurred in 1 of 1 walk-in refrigerator and had the potential to affect food served to residents.	F 812	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Upon deficient practice noted during the survey, all food items that were past date	2/13/25

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F 812	Continued From page 4 Findings included: An observation of the walk-in refrigerator on 01/21/25 at 9:22 AM with the Certified Dietary Manager (CDM) revealed the following: 1 a. A five pound container of sour cream dated 1/13 that had been opened and was available for use. During an interview on 01/21/25 at 9:22 AM the CDM revealed the date on the container was the date the sour cream was opened and she expected it to be discarded on 1/20/25, seven days after being in use. The CDM removed the container of sour cream from the walk-in refrigerator. c. Two containers of ham salad dated 1/20. During an interview on 01/21/25 at 9:22 AM the CDM revealed the date on the ham salad was the use by date and she expected both containers to have been discarded on 1/20/25. The CDM removed both containers of ham salad from the walk-in refrigerator. d. A half quart container of pinto beans dated 1/10 and 1/17. During an interview on 01/21/25 at 9:22 AM the CDM revealed the container of pinto beans was dated with both an open and used by date and she expected the beans to have been discarded on 1/17/25 according to the use by date. The CDM removed the container of pinto beans from the walk-in refrigerator. e. One large metal sheet pan of thawed raw	F 812	marked were discarded according to policy immediately after identification. A. 5lb container of sour cream was labeled with an opened by date of 1/13, the item was still being stored in the original manufacturer's container at which the expiration date listed on container was 2/13. Item removed from cooler on site. B. Two containers of ham salad were labeled 1/17- 1/20. These items were removed from the cooler on site. C. Half quart container of pinto beans. Item was removed immediately and discarded. D. Metal sheet pan with thawed raw chicken breast. Chicken was being stored on bottom of rack which is proper storage for raw chicken. Chicken was discarded immediately on site. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Since this deficient practice has the ability to affect all residents a complete audit of storage areas was done by designated staff member on 1/21/25 when problem identified. Areas continued to be checked daily in AM to ensure compliance. All items checked and ensured compliance with a label noted on items or it was discarded accordingly. Additional items out of date not noted again during survey.	

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F 812	Continued From page 5 chicken breast dated 1/20 stored on the bottom rack below other food items that were within the use by date and available for use. During an interview on 01/21/25 at 9:22 AM the CDM revealed the chicken was left over from 1/20/25 and should have been discarded on that day. The CDM further revealed it was the responsibility of the Kitchen Supervisor and dietary staff to check the dates on food items available for use and discard if out of date. During an interview on 01/22/25 at 4:38 PM the Kitchen Supervisor revealed he checked the walk-in refrigerator when he first arrived at work at approximately 6:45 AM and removed out of date food items. The Kitchen Supervisor revealed on 01/21/25 the food delivery truck had arrived, and he had not checked the walk-in refrigerator before the observation with the CDM and was why the out of date food items were not removed. During an interview on 01/24/25 at 1:02 PM the Administrator revealed if the use by date indicated a food item should be discarded those items should be removed and not stored in walk-in refrigerator and available for use.	F 812	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Additional in-service education completed with all Dietary staff regarding proper food storage, labeling of items and when to discard items completed on 2/11/25 and 2/12/25. Dietary Manager or designee will audit storage areas for label/dating issues as part of check-off list. Dietary Staff will comply with food storage policy and state food health code regulations that state items once opened will be labeled and dated according to item policy. All items in manufacturer's containers will be labeled and not used past manufacturer's use by date. Any new dietary staff will be education by Dietary Manager or designee regarding proper food storage the same way current staff were in-serviced. This will be on-going for any new hires. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Dietary manager or designee will review open/close checklist daily for completion and inspect storage areas daily ensure compliance. Documented open/close checklist to be obtained in AM and PM to ensure compliance. Upon 30-day compliance, Dietary Manager or designee will inspect weekly x3 months and monthly thereafter to ensure compliance. Checklist should be completed before any truck delivery. This will be documented on	

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F 812	Continued From page 6	F 812	open/close checklist regarding proper labeling/discarding of items stored in kitchen. Dietary Manager or Designee will also be a part of clinical care meeting held to report findings/compliance. In addition, Dietary Manager or designee will report findings to QAPI.	

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:
	345123	A. BUILDING: _____ B. WING _____	1/24/2025

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CAROLINA VILLAGE INC	600 CAROLINA VILLAGE ROAD SUITE Z HENDERSONVILLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the area of active diagnosis for 1 of 12 residents reviewed for MDS accuracy (Resident #14). Findings included: Resident #14 was admitted to the facility 11/07/24. A summary of a physician note dated 11/08/24 in part is as follows: Resident #14 was re-admitted to the facility with recent exacerbation (flare-up) of congestive heart failure. The assessment/plan was to obtain lab work and let the results guide diuretic therapy. The admission Minimum Data Set (MDS) dated 11/14/24 did not reflect Resident #14 had a diagnosis of congestive heart failure. An interview with the MDS Coordinator on 01/24/25 at 11:58 AM revealed Resident #14's admission MDS assessment should have reflected an active diagnosis of heart failure, and it was an oversight. An interview with the Director of Nursing (DON) on 01/24/25 at 12:24 PM revealed she expected MDS assessments to be coded correctly. An interview with the Administrator on 01/24/25 at 1:01 PM revealed he expected MDS assessments to be coded correctly.

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