STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A. BUILDING ______ B. WING ______	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE GREEN HEALTH AND REHABILITATION	**1601 PURDUE DRIVE FAYETTEVILLE, NC 28304**

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E 000	Initial Comments The survey team entered the facility 02/16/2025 to conduct a recertification and complaint investigation survey. The survey team was onsite 02/16/2025 through 02/18/2025 and were unable to return to the facility on 02/19/2025 and 02/20/2025 due to adverse weather conditions of snow and unsafe travel conditions. Therefore, the survey was completed remotely on 02/19/2025 and 02/20/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SDKW11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility 02/16/2025 to conduct a recertification and complaint investigation survey. The survey team was onsite 02/16/2025 through 02/18/2025 and were unable to return to the facility on 02/19/2025 and 02/20/2025 due to adverse weather conditions of snow and unsafe travel conditions. Therefore, the survey was completed remotely on 02/19/2025 and 02/20/2025. Event ID# SDKW11. The following intakes were investigated: NC00213670, NC00217946, NC00222780, NC00223477, NC00223628, NC00224256, NC00225313, NC00225631, NC00226170, NC00226634, NC00226691, NC00226998, and NC00227089. 44 of the 44 complaint allegations did not result in deficiency	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		2/27/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/27/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 2 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and family interviews the facility failed to implement an activity intervention on the comprehensive care plan for 1 of 22 residents (Resident #29). The findings included: Resident #29 was admitted into the facility on 11/22/23 with a diagnosis of dementia. A review of Resident #29's significant change Minimum Data Set assessment dated 10/28/24 revealed that she was severely cognitively impaired, had trouble falling or staying asleep, or sleeping too much for 12-14 days, trouble concentrating on things for 12-14 days, was sometimes understood and sometimes understood by others and had impaired vision. She had no behaviors and noted it was very important to have her family be part of the discussions regarding her care. A review of Resident #29's comprehensive care plan updated 12/19/24 revealed a problem of a need for daily stimulation by having her television and lights on daily in the morning. The goal and intervention to the problem included she would have her television and lights on by 10:00 AM each day. An interview was conducted with Resident #29's family member on 2/16/25 at 12:35 PM who	F 656	The facility failed to implement an activity intervention on the comprehensive care plan for 1 of 22 residents. On 02/18/2025, the Activity Director corrected the deficient practice immediately by opening the blinds and turning on the television for Resident #29. On 02/18/2025, The Administrator updated Resident #29s care card to ensure it accurately reflected the comprehensive careplan. On 02/18/2025, the Activity Director identified all other like-residents that are at risk and immediately began reviewing their activity comprehensive careplan and further observed all careplans were being followed, and their care cards were up to date. Any further deficient practices were corrected immediately. On 02/20/2025 an Ad Hoc Quality Assurance Performance Improvement Meeting was held to discuss the deficient practice and initiate a plan of correction with auditing tools. On 02/18/2025, the Administrator provided education to the Activity Director on review of comprehensive careplan, making updates as needed and following said plan of care. Subsequently, the	

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F 656 Continued From page 3

indicated a concern of Resident #29 not receiving any type of mental, tactile, or visual stimulation that the family member was aware of. The family member stated they visited the resident at different times during the week and that when they visited they always had to turn on the television and open the window blinds.

An observation of Resident #29's room on 2/16/25 at 12:30 PM noted the television and lights were not on, and the window blinds were closed. The resident was lying in bed with her eyes open.

Observations of Resident #29's room on 2/17/25 at 11:00 AM and 1:00 PM noted the television and lights were not on, and the window blinds were closed. Resident #29 was lying in bed with her eyes open.

An observation of Resident #29's room on 2/18/25 at 10:30 AM noted the blinds were open but the lights and television were not on. Resident #29 was lying in bed with her eyes open.

An interview conducted on 2/18/25 at 10:25 AM with Nurse Assistant #1, who was working on Resident #29's hall, revealed that if a resident had a daily task that needed to be completed it was placed on the resident care card at the desk. Nurse Assistant #1 was not aware of any resident's care cards that had a notation of the lights or television turned on by a certain time.

An interview conducted on 2/18/25 at 10:30 AM with Nurse Assistant #2, who was working on Resident #29's hall, indicated that any special tasks were on the resident care cards at the desk. She further indicated that she was not

F 656

Activity Director provided education to the Activity Aides on 02/20/2025 on following the activity comprehensive careplan. Additionally, the Minimum Data Set (MDS) Travel Consultant provided education to the MDS Coordinators on review of comprehensive careplan, making updates as needed, updating the care card, and following said plan of care on 02/18/2025. The Administrator provided education to the careplan team on 02/20/2025 regarding comprehensive careplan requirements, updating the care cards with changes and the importance of following the plan of care on 02/20/2025. New employees of the careplan team will receive education prior to starting their first shift. The MDS Coordinators will be responsible for ensuring education is received.

The Activity Director or Designee will audit compliance with activity comprehensive careplans (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, then weekly for four (4) weeks.
The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to the Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or

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F 656	Continued From page 4 aware of any residents that had a certain time for the lights or television to be on. A review of Resident #29's care card did not reveal instructions for the lights and television to be on by 10:00 AM each day. An interview with the Activity Director on 2/18/25 at 12:38 PM revealed that she was not aware the care plan had the problem of the resident need for stimulation by having the lights and television on by 10:00 AM and stated she had not created that care plan, the former Social Service Worker had, and that the former Social Service Worker should have put that on Resident #29's care card so the nursing assistants were aware. She further stated that the activity department provided one-on-one visits to Resident #29 on Tuesdays and Thursdays. A telephone interview with the Administrator on 2/20/25 at 9:44 AM indicated that the Activity Director should have been aware of the care plan problem regarding the lights and television on by 10:00 AM and the information should have been placed on Resident #29's care card so that the nursing assistants were aware.	F 656	adjustments to the plan of correction are necessary.	
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	F 812		2/27/25

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F 812	Continued From page 5 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 date opened food items and seal leftover frozen food stored in 1 of 1 reach-in freezer, 1 of 1 walk-in freezer, 1 of 1 dry goods storage area and failed to remove a bowl being used as a scoop observed nested in breadcrumbs in one of the dry ingredient storage bins in the kitchen. This practice had the potential to affect foods served to the residents. The findings included: On 02/16/25 at 11:28 A.M., an observation of the kitchen revealed the following: a. Reach-in freezer: - A plastic bag containing slider buns (this item had a label with 8/20/24 written in the "shelf life" spot on the label and 11/20/24 written in the "use by" spot on the label) - A zippered type of plastic storage bag containing pork loin with no date on it - A zippered type of plastic storage bag containing pulled chicken with no date on it b. Walk-in freezer: - A box of pre-cooked egg patties - the egg	F 812	The facility failed to date the opened food items and seal leftover frozen food stored in 1 of 1 reach-in freezer, 1 of 1 walk-in freezer, 1 of 1 dry goods storage area and failed to remove a bowl being used as a scoop observed nested in breadcrumbs in one of the dry ingredient storage bins in the kitchen. On 02/16/25, the cook immediately corrected the deficient practice by discarding out-of-date, open, and undated items. On 02/18/25, the Dietary Manager removed the bowl out of the breadcrumb container. Current facility residents have the potential to be affected by this deficient practice. The Dietary Manager completed a 100% audit of food storage including refrigerators, freezers, and dry storage rooms to ensure all food was within usage dates, properly stored, labeled, and items were properly disposed of as identified on 02/18/2025.	

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F 812	Continued From page 6 product was in the manufacturer's box and contained inside the box in a plastic bag; both the box and the plastic bag were left open to air and there was no date on it. c. Dry storage area: - An opened package of devil's food cake mix in a plastic package with no date on it. d. On 02/18/25 at 8:42 A.M., an observation of the kitchen revealed one of the white 3-bin dry ingredient storage bins contained a black bowl. The bowl had been left inside the bin and was observed in contact with the breadcrumbs being stored in the bin. The Dietary Manager, who was present during this observation, stated that she thought staff were using the bowl as a scoop and that it should not be stored inside the bin. An interview was conducted with the Dietary Manager (DM) on 02/18/25 at 11:28 A.M. The DM stated she thought staff were "moving too fast" as a possible reason why opened food items were not labeled or dated. When asked to explain what she meant, the DM gave an example of staff being busy on the line at mealtimes and had to run get an item for a resident and then forgot to go back after the busy period to properly label the food item that had been opened in a hurry. The DM stated it was her expectation that dietary staff seal opened food items appropriately and to label the items with the name of the item, the date it was opened and the expiration date of the item. An interview was conducted with the Administrator on 02/18/25 at 10:16 A.M. The Administrator stated it was her expectation that dietary and nursing staff label opened food items	F 812	On 02/20/2025, an Ad Hoc Quality Assurance Performance Improvement Meeting was held to discuss the deficient practice and initiate a plan of correction with auditing tools. On 02/19/2025, The Administrator provided education to The Dietary Manager on proper food storage requirements. Subsequently, the Dietary Manager began immediately educating all Dietary Staff on proper food storage requirements; all Dietary Staff will be educated prior to starting their next scheduled shift. New facility Dietary Staff will complete education prior to working their first shift. The Dietary Manager will be responsible for ensuring education is received. The Dietary Manager or Designee will audit refrigerators, freezers, dry storage, and nourishment rooms to ensure all food is within usage dates, properly stored, and labeled (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, then weekly for four (4) weeks. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to the Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the	

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F 812	Continued From page 7 with the date opened and a use-by date. The Administrator also stated that if the opened food item cannot be packaged for storage appropriately, it should be discarded.	F 812	effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary.	