STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 04/28/25 through 05/01/25. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness Event ID #E93M11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 04/28/25 through 05/01/25. Event ID #E93M11. The following intakes were investigated: NC00227543 & NC00229141. 2 of the 2 allegations did not result in a deficiency.	F 000		
F 641 SS=D	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 observations, record review, and staff interviews, the facility failed to accurately code a Minimum Data Set assessment when they failed to include a resident's diagnosis of neurogenic bladder for 1 of 1 resident reviewed for catheters. (Resident #74) The findings included: Resident #74 was admitted to the facility on 10/22/24 with diagnoses that included malignant neoplasm of prostate, aftercare following joint replacement surgery, and neuromuscular dysfunction of bladder. Review of Resident #74's quarterly Minimum	F 641	On 5/8/2025, the Minimum Data Set (MDS) Coordinator submitted a correction to the MDS dated 1/29/2025 for resident #74, indicating diagnosis of neurogenic bladder resulting in the need for a foley catheter. On 5/12/25, an audit of all the most recent MDSs for residents with a foley or suprapubic catheter was completed by the regional MDS nurse to ensure that the correct diagnosis was indicated on the resident's MDS. No other errors were identified. On 5/1/25, the Regional MDS nurse	5/13/25

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

Electronically Signed | 05/12/2025

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F 641	Continued From page 1 Data Set assessment dated 01/29/25 revealed Resident #74 was coded as having a catheter. Additionally, under section I, Resident #74 was not coded as having neurogenic bladder. Review of Resident #74's physician orders revealed the following order in part dated 01/07/25: Insert urethral indwelling urinary catheter due to neurogenic bladder. An interview with MDS Nurse #1 on 05/01/25 at 10:53 AM revealed information for diagnoses included in a Minimum Data Set assessment is typically retrieved from multiple sources that included nurse practitioner notes and hospital discharge summaries. She indicated she does not typically review physician orders in the system as the program should pull those diagnoses over into the Minimum Data Set assessment automatically. She reported she did not know what happened with Resident #74's quarterly Minimum Data Set assessment and reported he did have a diagnosis of neurogenic bladder and that it should have been accurately reflected in the quarterly Minimum Data Set assessment dated 01/29/25. An interview with the Director of Nursing on 05/01/25 at 11:09 AM revealed she believed diagnosis information for Minimum Data Set assessments is pulled from multiple areas including diagnosis lists, physician orders, discharge summaries, and physician notes. She stated that with Resident #74's catheter order indicating that it was used for neurogenic bladder, that the diagnosis should have been recorded in Resident #74's quarterly Minimum Data Set assessment dated 01/29/25. The Director of Nursing also indicated she expected Minimum	F 641	educated each facility MDS Coordinator on the importance of accuracy of the MDS, with special focus on the diagnosis section and the need to include all appropriate diagnoses to accurately reflect the resident's status per the Resident Assessment Instrument (RAI) User's Manual instructions for completing section I for diagnoses. An alternate MDS nurse will review each completed MDS for residents with foley or suprapubic catheters weekly x 8 weeks to ensure accuracy of the diagnosis supporting the resident's need for a foley or suprapubic catheter. The MDS audits will be reviewed monthly by the QAPI committee for any identified issues and/or the need for continued monitoring. Date of completion for this plan of correction is 5/13/25.	

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F 641	Continued From page 2 Data Set assessments to be accurate and reflect the individual resident and their care needs. An interview with the Administrator on 05/01/25 at 11:18 AM revealed she expected Minimum Data Set assessments to be accurate and reflect the individual resident and their care needs.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to ensure Resident #35 swallowed medication during medication administration for 1 of 2 residents reviewed for professional standards. The findings included: Resident #35 was admitted to the facility on 07/23/24 with diagnoses that included coronary artery disease, diabetes mellitus, peripheral vascular disease and Alzheimer's disease. Resident #35's quarterly Minimum Data Set assessment dated 11/20/24 revealed the Resident was cognitively intact. Resident #35's medical record revealed physician orders for *clopidogrel bisulfate 75 milligrams (mg) by mouth in the morning for peripheral vascular disease dated 02/05/25, acetaminophen	F 658	On 4/29/25, the Director of Nursing (DON) went to resident #35's room upon notification of medications being left at bedside. The DON remained at bedside until the resident #35 swallowed all of her medications. The DON educated nurse #1 that medications may not be left unattended with any resident and that in order to self-administer medications, a resident must be formally assessed, determined safe to self-administer medications, and care planned to self-administer medications. On 4/29/25, the DON and Unit Managers performed walking rounds to ensure no medications were left at the bedside of any other residents. No additional medications were found left at any other resident bedside.	5/13/25

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F 658	Continued From page 3 325 mg 2 tablets by mouth twice a day for pain dated 02/26/25, famotidine 20 mg by mouth twice a day for reflux dated 11/13/24, gabapentin 300 mg by mouth twice a day for neuropathy dated 02/17/25 and dapagliflozin propanediol 10 mg by mouth once a day for diabetes mellitus dated 11/14/24. On 04/29/25 at 8:37 AM an observation and interview were made of Resident #35 while she was lying in her bed eating breakfast. On the Resident's over bed table was a medicine cup that contained 6 pills. Resident #35 explained that it was her morning medication that some nurses leave with her and some do not. Resident #35 stated Nurse #1 gave her the medications that morning and placed them on the table. The Resident indicated she would take the medications when she was ready. On 04/29/25 at 8:47 AM an interview was conducted with Nurse #1 who explained that Resident #35 was "with it" so she thought it would be okay to leave her medications with her to take. The Nurse stated 04/29/25 was the first time she left Resident #35's medications at her bedside for her to take on her own. On 04/30/25 at 11:40 AM an interview was conducted with the Director of Nursing (DON). The DON explained that Resident #35 had not been assessed to be able to self-administer her medications and Nurse #1 should not have left the medications at her bedside. The DON indicated the nurses were educated to ensure the residents swallowed their medications and not leave them at their bedside.	F 658	On 5/12/2025, education was completed by the Staff Development Coordinator (SDC) nurse who educated all nurses and medication aides that medications may not be left at bedside and that residents must be properly evaluated and care planned to self-administer medications. All new staff members will be educated prior to working a shift. The DON/designee will conduct walking round audits 5 times a week for 8 weeks to ensure medications are not left at the bedside. The audits will be reviewed monthly by the QAPI committee for any identified issues and/or the need for continued monitoring by the DON. Date of completion for this plan of correction is 5/13/25.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More	F 759		5/13/25

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F 759	Continued From page 4 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, manufacturer's instructions, and staff and Pharmacy Consultant interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 26 opportunities, resulting in a medication error rate of 11.54% for 1 of 4 residents observed during the medication administration (Resident #17 and Resident #46). The findings included: 1. Resident #17 was admitted to the facility on 07/26/23 with diagnoses that included renal insufficiency, dyspnea, shortness of breath and vascular dementia. Resident #17's medical record revealed orders for *fluticasone-salmeterol (a corticosteroid) 100-50 MCG/ACT (microgram per actuation) one inhalation orally twice a day for shortness of breath. Rinse mouth after use dated 12/08/23 and *artificial tears 1% instill two drops in both eyes twice a day for dry eyes dated 04/03/24. The quarterly Minimum Data Set assessment dated 01/22/25 revealed Resident #17 was cognitively intact. On 04/29/25 at 8:59 AM an observation of a	F 759	On 4/29/25, the Director of Nursing (DON) assessed resident #17 following the reported medication errors. Resident #17 appeared to have no adverse effects from the medication errors. The errors were recorded as a medication error and reported to the provider with no new orders given. The bottle of eye drops was replaced with a new bottle. Resident #17 rinsed mouth at the time of assessment by DON. Nurse #1 was educated by the DON/designee, on 4/29/25, that doctor's orders must be followed as written. Residents must rinse their mouth following administration of steroid inhalers, when ordered by provider, to prevent negative side effects of the inhalers such as thrush or throat irritation, and residents may not self-administer medications without being properly assessed and care planned to do so. On 4/30/25, the Unit Manager nurse assessed resident #46 following the reported medication error. The resident appeared to have no adverse effects from the medication error. The error was recorded as a medication error and the	

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F 759	Continued From page 5 medication pass was made of Nurse #1 who was medicating Resident #17. Nurse #1 handed the Resident the inhaler and allowed the Resident to administer one puff and inhale the medication. Resident #17 did not rinse her mouth out nor did Nurse #1 instruct Resident #17 to rinse her mouth. Nurse #1 then attempted to instill the Resident's eye drops when Resident #17 stated she could do it herself and the Nurse handed the eye drops to the Resident. Resident #17 closed her eyes then drug the tip of the eye drop bottle over her left eye lashes then over her right eye lashes and again over her left eye lashes then stated, "that eye is worse." An interview was conducted with Nurse #1 at 9:16 AM on 04/29/25. The Nurse was asked what she thought about the medication pass to Resident #17 and the Nurse explained that the Resident did not instill the eye drops correctly because Resident #17 rubbed the tip of the bottle on her eye lashes and if she had an infection going on, bacteria could potentially be on the eye drop bottle now. The Nurse stated she would get a new bottle of eye drops for Resident #17. Nurse #1 stated that the Resident put more than two drops in each eye. When the Nurse was asked what she thought about the inhaler, Nurse #1 stated the Resident did not rinse her mouth out after she administered the inhaler to herself, nor did she instruct Resident #17 to rinse her mouth out. When asked why she did not instruct the Resident to rinse her mouth out the Nurse stated she was nervous. On 04/30/25 at 11:40 AM an interview was conducted with the Director of Nursing (DON). The DON explained that Resident #17 had not been assessed to be able to self-administer her	F 759	provider was notified of the error with no new orders given. Nurse #2 was educated by the DON/designee on 4/30/25 that insulin pens must be primed before each use to ensure that the appropriate amount of insulin is provided to the resident. On 4/29/25, an audit was initiated by the DON/designee by observing inhaler medication administration to all other residents on steroid inhalers with orders to rinse mouth after this medication administration to ensure they rinsed their mouth following administration of the inhaler. There were no other issues found. The audit was completed on 5/12/25. On 4/30/25, an audit was initiated the DON/designee by observing the administration of insulin for each resident that receives insulin to ensure that the insulin pen was primed prior to each use. There were no other issues found. The audit was completed on 5/12/25. On 5/12/25, education was completed by the Staff Development Coordinator who educated all nurses and certified medication aides on proper administration of steroid inhalers with emphasis placed on rinsing the mouth after administration when ordered by the provider and not allowing residents who have not been properly assessed and care planned to self-administer medications such as inhalers and eye drops.	

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F 759	Continued From page 6 medications and Nurse #1 should not have allowed the Resident to do so. The DON stated she felt Nurse #1 would have administered the medications correctly if she had done it herself. An interview was conducted with the Pharmacy Consultant on 04/30/25 at 2:10 PM who explained that the manufacturer's recommendation was for the residents to rinse their mouths after administering steroid inhalers because of the risk of thrush and some residents were at higher risk for thrush. The Pharmacy Consultant stated if the physician's order stated to rinse mouth after use, then it should be done. 2. The manufacturer's instructions for prefilled Lispro insulin pen indicated that priming the insulin pen each time was an important step to ensure there were no air bubbles in the insulin and the full dose of insulin was given. Priming the insulin pen: 1. Dial up 2 units: turn the dose selector dial to 2 units, 2. Prime the pen: Press the injection button to let out any air bubbles and ensure the insulin is flowing correctly, 3. Check for a drop of insulin: you should see a drop of insulin on the tip of the needle, 4. Repeat if necessary. Resident #46 was admitted to the facility on 10/26/23 with diagnoses that included diabetes mellitus. The quarterly Minimum Data Set assessment dated 02/13/25 revealed Resident #46 was cognitively intact. Resident #46's medical record revealed a physician order dated 04/02/25 for Lispro insulin via pen injector, inject 8 units subcutaneously	F 759	On 5/12/25, education was completed by the Staff Development Coordinator who educated all nurses on proper administration of insulin via insulin pens, with emphasis placed on the requirement to prime the pen prior to each use to ensure the appropriate amount of insulin is provided to the resident. All new nurses and certified medication aides will receive this education prior to working a shift in the facility. The DON/designee will conduct audits on 5 residents receiving steroid inhalers per week for 8 weeks to ensure nurses and certified medication aides are administering steroid inhalers properly by ensuring that the resident is rinsing his/her mouth after administration when it is ordered to do so by the provider. Audits will also include that the nurse and certified medication aides are not allowing residents to self-administer medication such as inhalers when they have not been properly assessed and care planned to do so. The DON/designee will conduct audits on 5 residents receiving eye drops per week for 8 weeks to ensure nurses and certified medication aides are administering eye drops properly by applying the eye drops per the provider orders. Audits will also include that the nurse and certified medication aides are not allowing residents to self-administer medication such as eye drops when they have not been properly assessed and care planned	

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F 759	Continued From page 7 before meals on Monday, Wednesday and Friday. On 04/30/25 at 11:31 AM an observation was made of Nurse #2 preparing to administer insulin to Resident #46 via an insulin pen. The Nurse removed the Lispro insulin pen from the medication cart and set the counter to 8 units. Nurse #2 administered the 8 units of insulin without priming the insulin pen as advised by the manufacturer's instructions. An interview was conducted with Nurse #2 at 11:37 AM on 04/30/25. The Nurse was asked to explain the procedure when giving insulin using an insulin pen and Nurse #2 stated she gave the insulin by the five rights of giving any medication. When the Nurse was asked if she was aware of priming the insulin pen before giving the insulin the Nurse stated she thought that was only for when the insulin pen was used for the first time. An interview was conducted with the Director of Nursing (DON) on 04/30/25 at 11:41 AM. The DON explained that it was the facility's policy to prime insulin pens before you inject the insulin prescribed to the resident and Nurse #2 should have primmed the insulin pen. During an interview with the Pharmacy Consultant on 04/30/25 at 2:14 PM the Pharmacy Consultant explained priming the insulin pen is recommended because there could be air bubbles in the chamber of the pen but there were very small incidences of that, but it had to be recommended. She indicated to prime the insulin pen was usually recommended with new pens.	F 759	to do so. The DON/designee will conduct audits on 5 nurses per week for 8 weeks to ensure that the appropriate dose of insulin is provided to the resident by observing that the nurse primes the insulin pen prior to each use. The audits will be reviewed monthly by the QAPI committee for any identified issues and/or the need for continued monitoring by the DON. Date of completion for this plan of correction is 5/13/25.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/13/25

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F 880	Continued From page 8 §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, 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:	F 880		

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F 880	Continued From page 9 (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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to follow their Handwashing/Hand Hygiene policy when the Wound Nurse performed a pressure ulcer treatment on Resident #51 and did not wash or sanitize her hands before donning new gloves. This practice occurred for 1 of 2 staff members (Wound Nurse) observed for infection control. The findings included:	F 880	On 4/29/25, the wound nurse was educated by the Director of Nursing (DON) that she must wash or sanitize her hands between glove changes as a means of infection prevention. On 4/30/25, an audit was initiated by DON/designee where 5 episodes of wound care were observed to ensure that during each episode soiled gloves were removed, hand hygiene was performed,	

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F 880	Continued From page 10 Review of the facility's policy entitled "Handwashing/Hand Hygiene" last revised in October 2015 read in part: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. 7. Use alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: m. After removing gloves. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves. On 04/29/25 at 10:45 AM an observation was made of the Wound Nurse performing wound care to Resident #51's stage IV sacral pressure ulcer. The Wound Nurse washed her hands and donned a gown, and gloves then set up a work surface in preparation for the wound care. The Wound Nurse removed the old dressing which had a moderate amount of drainage then removed her gloves and washed her hands before she applied new gloves. The Wound Nurse then cleansed the stage IV pressure ulcer and removed her gloves and without washing or sanitizing her hands she applied new gloves to continue the treatment by applying the medicated pad and border dressing to secure the wound. During an interview with the Wound Nurse on 04/29/25 at 10:55 AM the Wound Nurse was asked to review the steps of the wound care procedure. The Wound Nurse repeated the steps of the procedure and when she stated she removed her gloves after she cleansed the wound she stopped and stated, "I did not wash	F 880	and clean gloves were donned only after hand hygiene had been completed as a means of infection prevention. There were no additional observations of failure to perform hand hygiene and change gloves appropriately. The audit was completed on 5/12/25. On 5/12/25, education was completed by the Staff Development Coordinator who educated all nurses of the requirement to perform hand hygiene between glove changes during wound care and that after completing a wound treatment, soiled gloves must be removed, and hand hygiene must be performed. After hand hygiene is completed, clean gloves can be donned for the application of clean dressings. The education also included that hand hygiene is the primary means to prevent the spread of infection. All new nurses will receive the education prior to working a shift. The DON/designee will audit by observing wound care treatments 5 times per week for 8 weeks to ensure nurses are changing gloves and washing hands appropriately while performing treatments. The audits will be reviewed monthly by the QAPI committee for any identified issues and/or the need for continued monitoring by the DON. Date of completion for this plan of correction is 5/13/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 11 my hands before I put on new gloves." The Wound Nurse added she usually did wash her hands after she removed her gloves, but she was nervous being watched. At 10:57 AM on 10/29/25 an interview was conducted with the Director of Nursing (DON). The DON explained it was the facility's policy to utilize hand washing or sanitizing when gloves were removed. She stated the Wound Nurse should have sanitized her hands before donning new gloves.	F 880		