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 11/17/2022

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 survey was conducted onsite on 11/7/22 through 11/9/22. The facility was found in compliance with the requirement FR 483.73, Emergency Preparedness. Event ID #XYR311.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation was conducted on 11/7/22 through 11/9/22 with additional informtion obtained through 11/17/22. The credible allegation of compliance was validated on 11/17/22. Therefore, the exit date was changed to 11/17/22. 1 of the 4 complaint allegations was substantiated resulting in deficiencies. The following intakes were investigated NC00194150 and NC00194289. Intake #NC00194150 resulted in immediate jeopardy. Event ID #XYR311. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483. 12 at tag F610 at a scope and severity (J) The tags F600 and F610 constituted Substandard Quality of Care. Immediate Jeopardy began on 08/19/22 and was removed on 11/10/22. An extended survey was conducted on 11/17/22. The credile allegation was validated on 11/17/22.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		12/9/22

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

Electronically Signed | 12/07/2022

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F 600	Continued From page 1 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, family and staff interviews, the facility failed to protect a resident's right to be free from physical and/or emotional abuse for one of two residents sampled. The abuse occurred on 8/19/22 during the evening shift (3-11 PM). Nurse aide #4 (NA #4) reported she was standing in the hallway outside of a resident's room (Resident #336) when she observed NA #1 grab Resident #336's right arm while attempting to transfer her from her recliner chair to a bedside commode while Resident #336 was resistive to a bath. NA #1 did not allow Resident #336 the right to refuse care which resulted in a skin tear to Resident #336 right arm and according to interviews of a Family Member and Staff (NA #2, NA #3, and NA #4) caused Resident #336 to be fearful of NA #1 and not want her to care for her. The immediate jeopardy began on 08/19/22 when NA #4 witnessed NA #1 grab Resident #336's right arm to transfer her to the bedside commode	F 600	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all the applicable State and Federal regulatory requirements. Corrective action was accomplished for the alleged deficient practice by facility staff not notifying the Administrator or Director of Nursing (DON) of potential abuse as a result of a skin tear to a resident's arm. On 8/19/22 the resident was immediately assessed by the Assistant Director of Nursing (ADON) and the skin tear was cleaned and bandaged. On 8/22/22 the Director of Nursing (DON)	

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F 600	Continued From page 2	F 600		

which resulted in a skin tear to the right arm and Resident #336 being extremely fearful of being cared for by NA #1. The immediate jeopardy was removed on 11/10/22 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity "D" (no actual harm that is immediate jeopardy) to ensure monitoring systems that were put into place are effective.

Findings included:

1. Resident #336 was readmitted to the facility on 7/16/22 with a diagnosis of heart failure. Resident #336 expired on 9/10/22 under Hospice services.

A quarterly Minimum Data Set (MDS) dated 7/20/22 indicated Resident #336 was cognitively intact and required extensive assistance for bed mobility, toileting, and transfers. It further indicated Resident #336 had exhibited no behaviors, had no mental health diagnosis, and received no psychotropic medications.

A telephone interview on 11/8/22 at 11:57 AM with Nurse Aide (NA) #4 was conducted. NA #4 revealed she witnessed the alleged abuse from the doorway of Resident #336 on the evening shift of 8/19/22. NA #4 stated shortly after the shift began, she was standing in the hallway near Resident #336's room and overheard NA #1 and Resident #336 verbally talking. NA #4 stated Resident #336 told NA #1 she did not want a shower. NA #4 stated she immediately turned to the doorway because she was supposed to be the NA assigned to provide bathing for Resident #336 on this evening. NA #4 stated when she looked in the room, she noticed NA #1 grab

met with the resident and her daughter and educated them on safety measures and the bedside commode was moved away from the recliner to help prevent future incidents.

All other residents are at risk from suffering from the deficient practice and residents who are resistive to care were identified as more at risk for abuse.

On 11/8/22 all residents with a Brief Interview for Mental Status (BIMS) score of 9 or less received a head-to-toe skin assessment by licensed nurses to determine if there is evidence of abuse. None were found. On 11/9/22 all residents with a Brief Interview for Mental Status (BIMS) score of 10 or higher were interviewed to determine if any abuse has occurred. No concerns were found.

On 11/8/22 education was provided to the Administrator, Director of Nursing (DON), and the Staff Development RN by the Corporate Consultant, Regional Director of Operations, regarding the definition of abuse as defined in the abuse policy and the resident's right to be free from abuse.

On 11/8/22 - 11/9/22 after being reeducated as outlined above, education for all staff was completed in person and via phone by the Staff Development RN. The education consisted of the following: The definition of abuse, neglect and misappropriation of property and the need to immediately notify the Administrator or Director of Nursing (DON) of all issues

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F 600	Continued From page 3 Resident #336 right arm and transfer her roughly in a jerking motion from her recliner to the bedside commode. NA #4 stated she immediately entered the room and questioned NA #4 why she did grabbed Resident #336 in that way and NA #4 said to NA #1 "you can't do that". NA #4 indicated NA #1 said "you can't prove it; I'll say she did it herself on the bedside commode because she hurts herself often". NA #4 stated she immediately left the room and went to find a nurse. NA #4 indicated she thought the nurse was Nurse #4 but could not verify the nurses' identity for sure. NA #4 stated there were 2 to 3 nurses outside of the room when she exited, and she told an agency nurse who was outside the room at the time what she had witnessed between NA #1 and Resident #336. NA #4 stated later that night, Resident #336 expressed to her that she was fearful of NA #1 and felt like she handled her to roughly and doesn't listen when she said she did not want NA #1 to provide bathing care. NA #4 stated she also left a note under the door of the DON (Director of Nursing) later in the shift or on the following day to make her aware of what Resident #336 had reported to her because NA #1 was not removed from the care of Resident #336 following this incident and Resident #336 had told her she was afraid of NA #1 and did not want NA #1 to care for her anymore. A telephone interview on 11/9/22 at 11:07AM with NA #1 was conducted. NA #1 revealed she was assigned to care for Resident #336 on 8/19/22 during the evening shift. NA #1 indicated she had entered Resident #336's room to take her for her shower shortly after the shift began. NA #1 stated she was standing in front of Resident #336 when she dropped either her call light or recliner chair remote in the pocket of the recliner chair and	F 600	related to these infractions. If Administrator or Director of Nursing (DON) are not present in the facility, supervisors must be notified, and they must inform the Administrator or Director of Nursing (DON) immediately in person or by phone. Signs and symptoms of abuse and mental anguish such as loss of interest, change in routine, mood alterations, or difficulty eating. Our facility does not condone and has zero tolerance for resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. The education focused on tactics to deal with difficult residents such as walking away to allow for de-escalation, providing time/place orientation, using a soothing tone of voice, providing gentle tactile cueing, use of gestures, offering distractions such as activities, music, or person-centered strategies (pictures, personal memorabilia). This training will be provided by the Administrator or the Human Resource Director to all agency staff and new employees upon hire during orientation. All facility staff in all departments, including as needed and agency staff, received this training on 11/8/22 - 11/9/22 and all staff will continue to received the training yearly thereafter. The Administrator and Human Resource Director were notified by the Regional Director of Operations of the need to	

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F 600	Continued From page 4 reached down to obtain it and when she brought her arm up, she had a skin tear. NA #1 acknowledged she did transfer Resident #336 to the bedside commode in order to transfer her further to the wheelchair for her shower, but Resident #336 continued to refuse a shower so she left the room to make a nurse aware Resident #336 had sustained a skin tear that needed to be assessed. She indicated no one was in the room with her when the incident occurred; however, acknowledged NA #4 entered the room shortly after the incident occurred asking about what happened to Resident #336's arm. NA #1 would not elaborate on what was discussed between her and NA #4 other than NA #1 told NA #4 a skin tear had occurred. NA #1 indicated NA #4 quickly left the room and NA #1 went to tell the nurse on the cart about the skin tear. NA #1 thought the nurse she told was an agency nurse identified to be either Nurse # 4 or Nurse #5, but she could not be certain which she notified but stated there was either 2 to 3 nurses near the medication cart at the time. NA #1 vocalized sometime over the weekend she heard that Resident #336 had made accusations that staff had caused the injury which made her feel uncomfortable with caring for Resident #336 alone and NA #1 indicated she told a nurse who was on duty that day (unable to identify the nurse) and a few days after the skin tear occurred, she talked to the DON and Unit Manager about feeling it was best if Resident #336 was a 2 person gait belt transfer both for her safety and the safety of staff. NA #1 stated she continued to provide care for Resident #336 periodically until her death which was approximately 3 weeks after the incident because she felt that Resident #336 had confused her and another NA who formerly worked in the facility that fit a very similar	F 600	provide this training to new hires on 11/9/22. The Director of Nursing/Designee will conduct weekly audits for (10) residents for abuse weekly for (4) weeks, and (5) residents for abuse weekly for (4) weeks, and (3) residents weekly for (4) weeks. The Director of Nursing / Designee will report the results of the audits in the facility's monthly Quality Assurance Process Improvement (QAPI) meetings for (3) months and audits will continue at the discretion of the QAPI committee. The Director of Nursing is responsible for implementing the corrective action. The facility will be in full compliance with this Plan of Correction no later than 12/9/2022	

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F 600	Continued From page 5	F 600		

description of physical appearance and had worked with Resident #336 shortly before the incident occurred.

An offsite face to face follow-up interview on 11/10/22 at 11:00 AM with NA #1 was conducted at her request. NA #1 met with 2 surveyors from the team and revealed Resident #336 did not sustain the skin tear to her right arm by grabbing for a reacher (a device used assist to pick items up) nor on a bedside commode. NA #1 stated the skin tear occurred as a result of a white bedside table/cabinet which was near the residents' recliner chair before she was transferred. NA #1 acknowledged she had transferred Resident #336 for a shower but Resident #336 refused bathing assistance. NA #1 denied the interaction between her and NA #4 but acknowledged NA #4 entered the room shortly after the incident occurred asking Resident #336 what had happen and that NA #4 left the room and NA #1 was unsure where she went following being in Resident #336's room. NA #1 also stated when she came on shift, NA #4 and NA #3 had mentioned to her that she may not want to care for Resident #336 alone due to the allegation. NA #1 was uncertain if this notification happened on the start of the shift on 8/19/22 or over the weekend following (8/20/22 through 8/21/22) but was aware Resident #336 had alleged that "a NA" had caused the skin tear. NA #1 stated she felt as though Resident #336 had confused her identification and had her mixed up with NA #12. NA #1 stated she continued to believe it was an agency nurse she informed on 8/19/22; however, NA #1 was informed during a telephone conversation between her and the facility on 11/8/22 that it was believed by the facility to be the ADON (Assistant Director of Nursing). NA #1 further indicated

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THE GREENS AT VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

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F 600	Continued From page 6	F 600		

Resident #336 stated to both NA #1 and the nurse when the nurse entered the room to assess her, "Look what you did to me" but she thought she meant because they had to rearrange her belongings in her room and not because of the incident.

An interview with the ADON on 11/8/22 at 5:18 PM revealed she was the nurse who was assigned to care for Resident #336 on 8/19/22 during the evening shift. The ADON stated she recalled being outside in the hallway when the incident occurred and went in Resident #336's room when she heard the resident holler "Ow". The ADON stated she did not witness the alleged allegation; however, was able to confirm she saw NA #1 standing in front of Resident #336 when she entered the room to assess the resident. The ADON verified when she assessed Resident #336's skin on the evening of 8/19/22, there was an area approximately 1.5" by 1" where the skin was described as pushed backwards in a flap type fashion with minimal bleeding visible, but she could not recall seeing visible bruising at the time. The ADON said Resident #336 said she hurt her arm when she grabbed for a reacher, but the ADON could not verify exactly what Resident #336 had said.

A follow-up interview with the ADON on 11/9/22 at 11:58 AM revealed she was unsure why she had not completed a note in Resident #336's medical record on 8/19/22 with details surrounding the incident that occurred that resulted in a skin tear. The ADON stated she thought the DON had come to her on 8/23/22 and asked her to complete a note in the record of what she could recall from the incident because an accusation had been made against a nurse aide. During the

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	345080	A. BUILDING _____ B. WING _____	C 11/17/2022

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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
F 600	Continued From page 7	F 600		

interview, she could not recall if any other nurses or NAs were near the room when she was told about the skin tear by NA #1 but did recall she saw NA #1 standing in front of Resident #336 when she entered the room. The ADON explained she did not think to ask NA #1 to write a statement of what occurred following the incident but usually would do that for all incidents that occur.

A Situation Background Assessment Recommendation (SBAR) form completed by the ADON dated 8/19/22 indicated Resident #336 had a change in skin color or condition identified as a skin tear at approximately 4:30 PM.

A progress note written by the ADON dated 8/23/22 at 4:03 PM read in part: Late entry for 8/23/22 at 3:55 PM: "NA #1 brought Resident #336 out of her room to take a shower and stated Resident #336 dropped her call light and attempted to pick it up and scratched her arm on the bedside commode. Resident #336's right arm had a skin tear and she wanted to have a dressing applied. The ADON told Resident #336 to wait until after she had a bath, then the ADON would apply a dressing. The ADON went to the Wound Nurse and asked what dressing to apply to Resident #336's arm and the Wound Nurse told her to use Xerofoam and a dry dressing to the right arm. The ADON informed NA #1 that Resident #336's bedside commode needed to be set away from the resident's side so if she dropped any object then her arm would not hit her arm on the side of the chair."

A telephone interview on 11/9/22 at 2:56 PM with Nurse #4 revealed she could not recall Resident #336 or the skin tear.

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F 600	Continued From page 8	F 600		

Attempts were made to contact Nurse #5 without success.

A telephone interview on 11/8/22 at 11:47 AM with NA #3 was conducted. NA #3 revealed she learned of an incident with Resident #336 when she worked on the evening shift of 8/20/22. NA #3 stated she went in to see Resident #336 and noticed the bandage on her arm and bruising directly below the bandage and asked if she had to go to the hospital or if she had hurt herself. NA #3 stated Resident # 336 reported to her she had been grabbed by the arm by NA #1 on the day before which resulted in a skin tear and a dark bruise to the right arm. NA #3 stated following the report by Resident #336, she went to a nurse who was working the medication cart (unable to recall the nurses' name) and told her what Resident #336 had said. NA #3 stated that the nurse told her she was aware of the report and the DON had been made aware and seemed to think Resident #336 had hurt her arm on the bedside commode. NA #3 stated since she made the nurse aware she thought she would handle it further.

A telephone interview on 11/8/22 at 9:40 AM with NA #2 was conducted. Nurse Aide #2 revealed she learned of an incident with Resident #336 when she worked evening shift on 8/20/22. NA #2 stated Resident #336 reported to her she had been yanked up by the arm by NA #1 on the day before which caused some skin tears and bruises to the right arm. NA #2 stated following the report by Resident #336 along with the bandage on her arm and bruising directly below the bandage, she told her nurse on the unit (unable to recall nurses name) and was told they thought the injury had

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F 600	Continued From page 9	F 600		

occurred on the bedside commode on 8/19/22. NA #2 stated she also notified the DON at the time. NA #2 said she stated to the DON, "I'd rather do extra work and know the residents were taken care of than to have them mistreated by another staff member".

A telephone interview on 11/8/22 at 4:32 PM with Family Member was conducted. The family member stated several months ago while she was out of town on a Friday night (8/19/22), she received a phone call from the facility alerting her that Resident #336 had sustained a skin tear to the right upper extremity from her bedside commode. The family member stated initially she was not concerned with the incident because she was aware Resident #336 head sustained skin tears in the past. The family member explained she did not become concerned until she spoke to Resident #336 via phone over the weekend. The family member stated during a telephone conversation with the resident, Resident #336 notified her NA #1 had caused the skin tear during a transfer after Resident #336 had told NA #1 she did not want a shower and that NA #1 had told her that it would be her word against Resident #336's word and staff would believe NA #1 over the resident. The family member stated she arrived back in town late on Monday evening (8/22) and on Tuesday (8/23), while she was working, the family member received a phone call from Resident #336 stating Resident #336 needed the family member to come to the facility immediately because she was extremely fearful and upset. The family member recalled she was told NA #1 had returned to Resident #336's room to provide bathing assistance again on that day (8/23) and Resident #336 had told her she did not want her to give her a bath, but NA #1 told her, "I

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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
F 600	Continued From page 10	F 600		

did not ask if you wanted a bath, I am giving you one." The family member indicated she rushed to the facility and requested staff to alert the DON that she wished to speak to her urgently. The family member stated a few minutes after the request, she received a telephone call from the DON. During the phone call, the family member said she told the DON she was in the facility and to come to Resident #336's room, which she did. The family member reported when the DON arrived at Resident #336's room on 8/23/22, she questioned the DON about the skin tear Resident #336 had sustained and how it occurred and was told by the DON that Resident #336 had sustained it on the bedside commode on 8/19/22. Resident #336 stated in the presence of the family member and the DON that NA #1 had hurt her and caused the skin tear. NA #1 had arrived in the room again to make additional attempts to provide bathing and the family member explained Resident #336 pointed to NA #1 and stated she is the one that caused the skin tear and NA #1 left the room immediately. The family member stated the DON insinuated during this conversation Resident #336 was lying when she talked over her allegation and said "no, that is not what happened, remember, you got that on the bedside commode" and quickly changed the subject to start discussing how to transfer Resident #336 instead. The family member vocalized Resident #336 remained fearful of NA #1 for the remainder of her life (approximately 3 weeks) and begged the family member not to leave town again. The family member stated no one should not have been subject to that type of treatment and live in fear in the last days of their life.

An interview with the Wound Nurse on 11/9/22 at

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 11/17/2022

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THE GREENS AT VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

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F 600	Continued From page 11	F 600		

9:30 AM revealed she learned of the skin tear to Resident #336's arm when she was asked by the ADON on 8/23/22 to obtain an order for treatment. The Wound Nurse stated she was not aware of the incident on 8/19/22 when it occurred or she would have assessed the area, made a note, and obtained and wrote a treatment order in the medical record. The Wound Nurse stated Resident #336 had sustained skin tears in the past and therefore at the time of the interview could not recall exactly what the skin tear to Resident #336's right arm looked like when she saw it on 8/23/22, but verified she obtained and wrote the order for treatment in Resident #336's medical record on that date.

An interview with the DON and Administrator on 11/8/22 at 10:57 AM was conducted. They both indicated they had no knowledge of the allegation of abuse. The DON recalled she had previously spoke to Resident #336's family when the skin tear occurred; however, did not recall any conversation surrounding the allegation against NA #1.

A follow-up interview with the DON on 11/8/22 at 5:03 PM revealed she was very familiar with Resident #336 and indicated Resident #336 always sat in a recliner and refused to lay in a bed. She also indicated Resident #336 had previously been able to transfer herself independently from the recliner to the bedside commode with the use of her walker; however, after her most recent admission, she required additional assistance from staff. The DON explained Resident #336 was alert and oriented and able to make her needs known to staff. The DON stated the family member came in the facility to visit her mom regularly and was in the

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F 600	Continued From page 12	F 600		

facility within a day or two after the incident (skin tear) occurred and Resident #336 had told her that she had not been the one to cause the skin tear but did not name anyone that caused it, but she reminded Resident #336 that the incident occurred from her bedside commode as a result of the need for safer transfer techniques and continued discussing interventions to protect Resident #336's skin and safe transfer techniques. The DON verified no incident report was completed and no witness statements were obtained at the time of the incident because the facility felt this incident to be an ordinary skin tear that didn't look suspicious. The DON stated she was not present and verified she did not witness the alleged abuse.

An additional follow-up interview with the DON on 11/9/22 at 12:25 PM stated she had no knowledge of the allegation until the survey team entered the facility on 11/7/22. The DON indicated she had been educated, with all incidents, the interdisciplinary team should review them on the next day during clinical meeting to ensure a root cause had been identified, a nurses note, a SBAR and incident report completed, and orders obtained and entered the EMR.

The Administrator, Director of Nursing, and a corporate consultant were notified of immediate jeopardy on 11/9/22 at 5:30 PM.

The facility provided the following credible allegation for IJ removal:

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

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F 600	Continued From page 13	F 600		

* On 8/19/22 the facility failed to protect a resident's right to be free from physical abuse.

* On 8/19/22 resident #336 sustained a skin tear and mental anguish as a result of physical abuse.

*All other residents are at risk from suffering from the deficient practice and resident who are resistive to care were identified as more at risk for abuse.

On 11/9/22, an audit of all residents with a Brief Interview of Mental Status (BIMS) of 10 or above, was completed by the DON, ADON, and Unit Managers or designee to determine if they have experienced any type of resident abuse. No concerns were found.

On 11/8/22, an audit consisting of thorough skin assessment of all residents with a BIMS of 9 or less was completed by licensed nurses to determine if there is evidence of abuse. No concerns were found.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

0n 11/8/22, education was provided to the Administrator, DON, and the Staff Development RN by the Corporate Consultant, Regional Director of Operations, regarding the definition of abuse as defined in the abuse policy and the resident's right to be free from abuse.

On 11/8/22 - 11/9/22, after being reeducated as outlined above, education for all staff was completed in person and via phone by the Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 14	F 600		

Development RN. The education consisted of the following:

" The definition of abuse, neglect and misappropriation of property and the need to immediately notify the Administrator or DON of all issues related to these infractions. If Administrator or DON are not present in facility, supervisors must be notified, and they must inform the Administrator or DON immediately in person or by phone

" Signs and symptoms of abuse and mental anguish such as loss of interest, change in routine, mood alterations, or difficulty eating

" Our facility does not condone and has zero tolerance for resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals.

" the education focused on tactics to deal with difficult residents such as walking away to allow for de-escalation, providing time/place orientation, using a soothing tone of voice, providing gentle tactile cueing, use of gestures, offering distractions such activities, music, or person-centered strategies (pictures, personal memorabilia)

This training will be provided by the Administrator or the Human Resource Director to all agency staff and new employees upon hire during orientation. All facility staff in all departments, including as-needed and agency staff, received this training on 11/8/22-11/9/22 and all staff will continue to receive the training yearly thereafter. The Administrator and Human Resource Director were notified by the Regional Director of Operations of the need to provide this training to

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F 600	Continued From page 15 new hires on 11/9/22. Alleged IJ removal date is 11/10/22. On 11/17/22 the credible allegation of IJ removal with a completion date of 11/10/22 was validated through staff interview and review of in-service training records. Staff were able to verbalize examples of abuse to include physical, mental, emotional, financial and sexual. Each were able to verbalize they were to report all susupected or allegations of abuse regardless of source to the Administrator and the Director of Nursing to include after hours and weekends.	F 600		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews family and staff	F 610	Preparation, submission and	12/9/22

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F 610	Continued From page 16	F 610		

interviews, the facility failed to protect all residents in the facility when Nurse Aide #1 (NA #1) was allowed to continue to care for residents after an allegation of abuse was made against her and according to interviews of a Family Member and Staff (NA #2, NA #3, and NA #4) caused Resident #336 to be fearful of NA #1 and not want her to care for her. The facility also failed to investigate an allegation of abuse made by a cognitively intact resident and failed to report the allegation to the State Agency (SA), Adult Protective Services (APS) and local law enforcement for 1 of 2 residents reviewed for abuse (Resident #336).

The immediate jeopardy began on 8/19/22 when NA #1 was allowed to continue to provide care to residents in the facility after an allegation of abuse was made against NA #1 which resulted in a skin tear and bruising to Resident #336's right arm and according to staff and family interviews left Resident #336 fearful of NA #1. The immediate jeopardy was removed on 11/10/22 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity "D" (no actual harm that is immediate jeopardy) to ensure monitoring systems are put into place are effective.

Findings included:

1. Resident #336 was readmitted to the facility on 7/16/22 with a diagnosis of heart failure. Resident #336 expired on 9/10/22 under Hospice services.

A quarterly Minimum Data Set (MDS) dated 7/20/22 indicated Resident #336 was cognitively intact and required extensive assistance for bed

implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all the applicable State and Federal regulatory requirements. Corrective action was accomplished for the alleged deficient practice when the facility failed to identify, protect, assess other residents, and thoroughly investigate an allegation of abuse when Resident received a skin tear during transfer while being resistive to care.

On 11/9/22 a 24 hour report was filed by the Administrator. Law Enforcement and Adult Protective Services were notified.

On 11/9/22 the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and (2) Unit Managers immediately began the investigation into the alleged abuse. The findings of this investigation were that the abuse was unsubstantiated. The Department of Health and Human Services/Health Care Personnel Registry Sections Determined that no further investigation will be conducted in this case.

All residents are at risk from suffering from the deficient practice and residents who are resistive to care are the ones more at risk for abuse.

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F 610	Continued From page 17 mobility, toileting, and transfers. It further indicated Resident #336 had exhibited no behaviors. A telephone interview on 11/8/22 at 11:57 AM with Nurse Aide (NA) #4 was conducted. NA #4 revealed she witnessed the allegation of abuse from the doorway of Resident #336 on the evening shift of 8/19/22. NA #4 stated shortly after the shift began, she was standing in the hallway near Resident #336's room and heard NA #1 and Resident #336 verbally talking in an undignified manner. NA #4 stated Resident #336 was resistive to allowing NA #1 to provide bathing assistance and told her she did not want a shower. NA #4 stated she immediately turned to the doorway because she was supposed to be the NA assigned to provide bathing for Resident #336 on this evening. NA #4 stated when she looked in the room, she noticed NA #1 grab Resident #336 by the right arm and transfer her roughly almost jerking motion from her recliner to the bedside commode. NA #4 stated she immediately entered the room and questioned NA #4 why she did that and NA #4 said to NA #1 "you can't do that". NA #4 indicated NA #1 said "you can't prove it; I'll say she did it herself on the bedside commode because she hurts herself often". NA #4 stated she immediately left the room and went to find a nurse. NA #4 indicated she thought the nurse was Nurse #4 but could not verify the nurses ' identity for sure. NA #4 stated there were 2 to 3 nurses outside the room when she exited, and she told an agency nurse who was outside the room at the time. NA #4 stated she also left a note under the door of the DON later in the shift or on the following day because NA #1 was not removed from the care of Resident #336 following this incident and	F 610	On 11/9/22, an audit was completed by interviewing all residents with a Brief Interview of Mental Status (BIMS) of 10 or above by Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers or designee to determine who could alert staff to instances of abuse. These residents were interviewed for unreported abuse occurrences. No other residents were identified as being abused and not reported. On 11/8/22, an audit consisting of thorough skin assessment of all residents with a BIMS of 9 or less was completed by licensed nurses to determine if there is evidence that these residents have experienced any type of abuse. No other residents were identified as being abused and not reported. On 11/9/2022 -11/10/22, all staff in all departments were interviewed by members of the interdisciplinary team (IDT) that consists of Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and (2) Unit Managers to determine if any other resident may have been affected and if they had observed and not reported any abuse. No concerns identified. On 11/9/22, the Assistant Director of Nursing (ADON) was reeducated on how to respond to situations where potential abuse may have occurred to include assessing the situation, removing a potential perpetrator from the resident, and reporting to the DON and/or	

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	345080	A. BUILDING _____ B. WING _____	C 11/17/2022

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

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F 610	Continued From page 18 Resident #336 had told her she was afraid of NA #1 and did not want NA #1 to care for her anymore. A telephone interview on 11/9/22 at 11:07AM with NA #1 was conducted. She indicated no one was in the room with her when the incident occurred; however, acknowledged NA #4 entered the room shortly after it occurred asking about what happened to Resident #336's arm. NA #1 indicated NA #4 quickly left the room and NA #1 went to tell the nurse on the cart whom she thought was an agency nurse identified to be either Nurse # 4 or Nurse #5 she could not be certain which she notified but stated there was either 2 to 3 nurses near the medication cart at the time. NA #1 vocalized sometime over the weekend she heard that Resident #336 was making accusations that staff had caused the injury which made her feel uncomfortable with caring for Resident #336 alone and NA #1 indicated she told a nurse who was on duty that day. A few days after the initial incident, she talked to the DON and Unit Manager about feeling it was best if Resident #336 was a 2-person gait belt transfer both for her safety and the safety of staff. NA #1 stated she continued to provide care for Resident #336 periodically until her death which was approximately 3 weeks after the incident because she felt that Resident #336 had confused her and another NA who formerly worked in the facility that fit a very similar description of physical appearance and had worked with Resident #336. NA #1 stated she felt as though Resident #336 was confused in her identification and had her confused with NA #12. NA #1 stated she continued to believe it was an agency nurse she informed on 8/19/22; however, NA #1 was informed during a telephone	F 610	Administrator On 11/8/22, the Administrator, Director of Nursing (DON), and Staff Development RN were also reeducated on all components of the facility□s abuse policy and how to identify abuse by the Regional Director of Operations. Education included the definition of abuse, reporting requirements, the need to conduct a thorough investigation, and monitoring for psychosocial changes by qualified individuals, as well as immediately separating the victim from the alleged perpetrator. On 11/9/22, after being reeducated as outlined above education for all staff was completed by the Staff Development RN. The education consisted of the following: " The definition of abuse and the need to immediately notify the Administrator or Director of Nursing (DON) of all issues related to these infractions. If Administrator or Director of Nursing (DON) are not present in facility, supervisors must be notified, and they must inform the Administrator or Director of Nursing (DON) immediately in person or by phone " Staff members who observe situations of abuse should immediately intervene to prevent continued potential abuse to residents. The perpetrator should be removed from the situation and placed under 1:1 supervision by the immediate supervisor or designee until they can be removed from premises or restricting visitation for accused	

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	345080	A. BUILDING _____ B. WING _____	C 11/17/2022

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

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F 610	Continued From page 19	F 610		

conversation between her and the facility on 11/8/22 that it was believed to be the ADON. NA #1 further indicated Resident #336 stated to both NA #1 and the nurse when the nurse came to the room to assess her, "Look what you did to me" but she thought she meant because they had to rearrange her belongings in her room and not as a result of the incident. A follow-up interview with NA #1 on 11/10/22 at 11:00 AM revealed the skin tear did not occur as a result of a bedside commode but according to NA #1 it was from a white bedside table or cabinet which was near Resident #336's recliner chair. NA #1 also explained at the time of the incident, Resident #336 stated to both NA #1 and the nurse when the nurse came to the room to assess her, "Look what you did to me" but she thought she meant because they had to rearrange her belongings in her room and not as a result of the incident.

A verification of employment for NA #12 determined her employment was terminated prior to the incident involving Resident #336 on 8/19/22.

An interview with the ADON on 11/8/22 at 5:18 PM revealed she was the nurse who was assigned to care for Resident #336 on 8/19/22 during the evening shift. The ADON stated she recalled being outside in the hallway when the incident occurred and went in Resident #336 ' s room when she heard the resident holler "Ow". The ADON stated she did not witness the alleged allegation; however, was able to confirm she saw NA #1 standing in front of Resident #336 when she entered the room to assess the resident. The ADON verified when she assessed Resident #336's skin on the evening of 8/19/22, there was an area approximately 1.5" by 1" where the skin

individuals not employed by the facility
" Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing (DON). The following information should be reported:
a. The name(s) of the resident(s) to which the abuse or suspected abuse occurred
b. The date and time that the incident occurred
c. Where the incident took place
d. The name(s) of the person(s) allegedly committing the incident, if known
e. The name(s) of any witnesses to the incident
f. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.)
g. Any other information that may be requested by management.
" The individual conducting the investigation will, as a minimum:
a. Review the completed documentation forms
b. Review the resident□s medical record to determine events leading up to the incident
c. Interview the person(s) reporting the incident
d. Interview any witness to the incident
e. Interview the resident (as medically appropriate)
f. Interview the residents attending physician as needed to determine the resident□s current level of functioning and cognitive condition
g. Interview staff members on all shifts

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

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F 610	Continued From page 20	F 610		

was described as pushed backwards in a flap type fashion with minimal bleeding visible, but she could not recall seeing visible bruising at the time. The ADON said Resident #336 said she hurt her arm when she grabbed for a reacher (a device used to aide a person to pick up items), but the ADON could not verify exactly what Resident #336 had said.

A follow-up interview with the ADON on 11/9/22 at 11:58 AM revealed she was unsure why she did not complete a note in Resident #336's medical record on 8/19/22 with details surrounding the incident that occurred that resulted in a skin tear. The ADON stated she thought the DON had come to her on 8/23/22 and asked her to complete a note in the record of what she could recall from the incident because an accusation had been made against a nurse aide. The ADON stated she went to the Wound Nurse who provided her an order for the treatment of Resident #336's right arm skin tear. The ADON explained she did not think about asking NA #1 to write a statement of what occurred following the incident but usually would do that for all incidents that occur. When asked if she assists with any investigations of incidents in the facility, she indicated all investigations are conducted by the DON.

A Situation Background Assessment Recommendation (SBAR) form completed by the Assistant Director of Nursing (ADON) dated 8/19/22 indicated Resident #336 had a change in skin color or condition identified as a skin tear at approximately 4:30 PM but included no other details surrounding the incident.

There was not a nurses note in the medical

who have had contact with the resident during the period of the alleged incident
h. Interview the resident□s roommate, family members, and visitors
i. Interview other residents to whom the accused employee provides care of services; and
j. Review all events leading up to the alleged incident
k. Preserve all audio and video recordings of the incident (if applicable)
" In effort to protect residents from abuse, education included identification strategies for signs and symptoms of abuse such as physical abnormality, withdrawal, loss of appetite, and general changes in patterns and psychosocial well-being
" Also, in effort to provide protection from abuse, keeping residents engaged in their community, supporting primary caregivers by identifying caregivers who appear stressed or need a break from working with difficult residents. (This situation should also be brought to the immediate attention of the supervisor.)
" The fact that our facility does not condone and has zero tolerance for resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals.

This training will be provided by the Administrator or the Human Resource

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE GREENS AT VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

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F 610	Continued From page 21 record dated 8/19/22 which would include additional details regarding the skin tear to Resident #336's right arm or the bruising. A progress note written by the ADON dated 8/23/22 at 4:03 PM read in part: Late entry for 8/23/22 at 3:55 PM: "NA #1 brought Resident #336 out of her room to take a shower and stated Resident #336 dropped her call light and attempted to pick it up and scratched her arm on the bedside commode. Resident #336's right arm had a skin tear and she wanted to have a dressing applied. The ADON told Resident #336 to wait until after she had a bath, then the ADON would apply addressing. The ADON went to the Wound Nurse and asked what dressing to apply to Resident #336's arm and the Wound Nurse told her to use "Xerofoam" and a dry dressing to the right arm. The ADON informed NA #1 that Resident #336's bedside commode needed to be set away from the resident's side so if she dropped any object then her arm would not hit her arm on the side of the chair." A telephone interview on 11/9/22 at 2:56 PM with Nurse #4 revealed she was unable to recall Resident #336 or the skin tear. Attempts were made to contact Nurse #5 without success. A telephone interview on 11/8/22 at 11:47 AM with NA #3 was conducted. NA #3 revealed she learned of an incident with Resident #336 when she worked on the evening shift of 8/20/22. NA #3 stated she went in to see Resident #336 and noticed the bandage on her arm and asked if she had to go to the hospital or if she had hurt herself. NA #3 stated Resident # 336 reported to her she	F 610	Director to all agency staff and new employees upon hire during orientation. All facility staff in all departments, including as-needed and agency staff, received this training on 11/8/22-11/9/22 and all staff will continue to receive the training yearly thereafter. The Administrator and Human Resource Director were notified by the Regional Director of Operations of the need to provide this training to new hires on 11/9/22. The Director of Nursing/Designee will conduct weekly audits for (10) staff members for abuse reporting weekly for (4) weeks, and (5) staff members for abuse reporting weekly for (4) weeks, and (3) staff members for abuse reporting weekly for (4) weeks to ensure the plan of correction is effective and remains in compliance with the regulatory requirement. The Director of Nursing/Designee will report the results of the audits in the facility□s monthly Quality Assurance Process Improvement (QAPI) meetings for (3) months and audits will continue at the discretion of the QAPI committee. The Director of Nursing is responsible for implementing the corrective action. The facility will be in full compliance with this plan of correction no later than 12/9/2022.	

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 11/17/2022

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

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F 610	Continued From page 22	F 610		

had been grabbed by the arm by NA #1 on the day before which resulted in a skin tear and a dark bruise to the right arm. NA #3 stated following the report by Resident #336, she went to a nurse who was working the medication cart (unable to recall the nurses' name) and told her what Resident #336 had said. NA #3 stated that nurse told her she was aware of the report and the DON had been made aware and seemed to think Resident #336 had hurt her arm on the bedside commode, so she was not sure if the DON planned to further investigate the incident reported by Resident #336. NA #3 stated since she made the nurse aware she thought she would handle it further.

A telephone interview on 11/8/22 at 9:40 AM with NA #2 was conducted. Nurse aide #2 revealed she learned of an incident with Resident #336 when she worked evening shift on 8/20/22. NA #2 stated Resident #336 reported to her she had been yanked up by the arm by NA #1 on the day before which caused some skin tears and bruises to the right arm. NA #2 stated following the report by Resident #336, she told her nurse on the unit and was told they thought the injury had occurred on the bedside commode on 8/19/22. NA #2 stated she also notified the DON at the time and was told the DON was "unable to terminate everyone that might be doing something incorrectly or the facility would not have anyone to take care of her residents". NA #2 said she stated to the DON, "I'd rather do extra work and know the residents were taken care of than to have them mistreated".

A telephone interview on 11/8/22 at 4:32 PM with a Family Member was conducted. The Family member stated several months ago while she

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 11/17/2022

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
F 610	Continued From page 23	F 610		

was out of town on a Friday night, she received a phone call from the facility alerting her that Resident #336 had sustained a skin tear to the right upper extremity from her bedside commode. The Family Member stated initially she was not concerned with the incident because she was aware Resident #336 head sustained skin tears in the past. The family member stated she did not become concerned until she spoke to her mother via phone over the weekend. The Family Member stated during a telephone conversation, Resident #336 had notified her NA #1 had caused the skin tear during a transfer after Resident #336 had told NA #1 she did not want a shower and that NA #1 had told her that it would be her word against Resident #336's word and staff would believe staff over the resident. The Family Member stated she arrived back in town late on Monday evening from a flight and on Tuesday, while she was working, Family Member received a phone call from Resident #336 stating Resident #336 needed Family Member to come to the facility immediately. Family Member recalled she was told NA #1 had returned to Resident #336's room to provide bathing assistance again on 8/23/22 and Resident #336 had told her she did not want her to give her a bath, but NA #1 told her, "I did not ask if you wanted a bath, I am giving you one." Family Member stated she rushed to the facility and requested staff to alert the DON that Family Member wished to speak to her urgently. Family Member stated a few minutes after the request, she received a telephone call from the DON. During the phone call, Family Member says she told the DON she was in the facility and to come to Resident #336's room, which she did. Family Member #1 indicated when the DON arrived at Resident #336's room on 8/23/22 shortly after evening shift began, she questioned

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 11/17/2022

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
F 610	Continued From page 24	F 610		

the DON about the skin tear Resident #336 had sustained and how it occurred and was told by the DON that Resident #336 had sustained it on the bedside commode on 8/19/22. Resident #336 stated in the presence of Family Member and the DON that NA #1 had hurt her and caused the skin tear. NA #1 had arrived in the room again to make additional attempts to provide bathing and Family Member reported Resident #336 pointed to NA #1 and stated she is the one that caused the skin tear and NA #1 left the room immediately. Family Member stated the DON insinuated Resident #336 was lying when she talked over her allegation and said "no, that is not what happened remember, you got that on the bedside commode" and quickly changed the subject to start discussing how to transfer Resident #336 instead. Family Member stated Resident #336 remained fearful of NA #1 for the remainder of her life (approximately 3 weeks) and begged Family Member not to leave town again. Family Member stated no one should be subjected to that type of treatment and live in fear in the last days of their life.

An interview with the DON and Administrator on 11/8/22 at 10:57 AM was conducted. They both indicated they had no knowledge of the allegation of abuse. The DON recalled she had previously spoke to Resident #336 ' s family when the skin tear occurred; however, did not recall any conversation surrounding the allegation against NA #1.

A follow-up interview with the DON on 11/8/22 at 5:03 PM revealed the family member came in the facility to visit her mom within a day or two after the incident occurred and Resident #336 had told her that she was not the one who caused the skin

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 11/17/2022

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
F 610	Continued From page 25	F 610		

tear, but she reminded Resident #336 that the incident occurred from her bedside commode as a result of the need for safer transfer techniques and continued discussing interventions to protect Resident #336's skin and safe transfer techniques. The DON verified no incident report was completed and no witness statements were obtained because the facility felt this incident to be an ordinary skin tear that 't look suspicious. The DON stated she was not present and verified she did not witness the alleged abuse. The DON stated she was aware Resident #336 had been resistive to staff providing bathing assistance due to hospice staff providing bathing on a rotating schedule where hospice staff and facility staff each provided one bath each per week.

An additional follow-up interview with the DON on 11/9/22 at 12:25 PM stated she had no knowledge of the allegation until the survey team entered the facility on 11/7/22. The DON indicated she had been educated, with all incidents, the interdisciplinary team should review them on the next day during clinical meeting to ensure a root cause had been identified, a nurses note, a SBAR and incident report completed, and orders obtained and entered the medical record. The DON did not recall a conversation between herself, Family Member, and Resident #336 on 8/23/22 where the skin tear was discussed or that Family Member indicated she did not want NA #1 caring for her family member, but strictly discussed the skin tear and reviewed transfer status and provided Resident #336 with a gait belt to remind her to call for assistance and left the room and thought both Family Member #1 and Resident #336 to be satisfied with the resolution.

A review of nursing staff scheduling sheets

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 11/17/2022

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

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F 610	Continued From page 26	F 610		

provided by the facility dated 8/19/22 through 8/23/22 indicated the following:
On 8/19/22, the schedule indicated Nurse #1, NA #1 and NA #4 were assigned to Resident #336 hall on evening shift. The documents further indicated NA #3 was also assigned to work on the evening shift; however, NA #3 was assigned to work an adjacent hall. It further detailed NA #4 was assigned to work the night shift (11PM- 7 AM) on 08/19/22.
On 8/20/22, the schedule indicated Nurse #2 was assigned to Resident #336 from 7AM-7PM and Nurse #3 was scheduled from 7PM-7AM. The schedule further indicated NA #1 and NA #3 were scheduled to provide care to Resident #336 on the evening shift; however, NA #2 was scheduled but assigned to work on an adjacent hall.
On 8/21/22, the schedule indicated Nurse #1 was assigned to Resident #336 from 7AM-11PM and NA #1 was assigned to Resident #336 ' s care from 4 PM-11 PM. The schedule further indicated NA #2 was assigned to work, however on an adjacent hall.
On 8/22/22, the schedule indicated Nurse #4 was assigned to Resident #336 from 7 AM to 3 PM and NA #3 was assigned to the resident from 5:30 PM to 11 PM and NA #4 was assigned to the resident from 11 PM to 7 AM.
On 8/23/22, NA #1 and NA #2 were assigned to the care of Resident #336 from 3 PM to 11 PM. Nurse #1 was assigned to Resident #336 ' s care from 7 AM- 11 PM.
According to the Nurse Aide Documentation Report dated August 2022 and comparison staff initial report for verification of documented initials provided by the facility, NA #1 also provided care for Resident #336 on 8/26 and 8/30 on the evening shift.

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 11/17/2022

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

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F 610	Continued From page 27	F 610		

A review of facility reported incidents (FRIs) for August 2022 through 11/7/22 revealed no reports of an allegation of abuse involving NA #1 and Resident #336 filed to the State Agency (SA), Adult Protective Services (APS), or local law enforcement.

The Administrator, Director of Nursing, and a corporate consultant were notified of immediate jeopardy on 11/9/22 at 5:30 PM.

The facility provided the following credible allegation of IJ removal:

·Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

*On 8/19/22, the facility failed to identify, protect, assess other residents, and thoroughly investigate an allegation of abuse. The facility failed to notify law enforcement and APS when NA #4 witnessed NA #1 abuse resident #336 and the facility administration was aware that the resident was fearful of the aide. The perpetrator continued to be assigned to provide care for this resident until the resident's death.

*All residents are at risk from suffering from the deficient practice and residents who are resistive to care are the ones more at risk for abuse.

On 11/9/22, a 24-hour report was made to DHSR. Law enforcement and Adult Protective Services were notified. An investigation around this incident is underway. This investigation is being conducted by the Administrator.

On 11/9/22, an audit was completed by

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 11/17/2022

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

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F 610	Continued From page 28	F 610		

interviewing all residents with a Brief Interview of Mental Status (BIMS) of 10 or above by Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers or designee to determine who could alert staff to instances of abuse. These residents were interviewed for unreported abuse occurrences. No other residents were identified as being abused and not reported.

On 11/8/22, an audit consisting of thorough skin assessment of all residents with a BIMS of 9 or less was completed by licensed nurses to determine if there is evidence that these residents have experienced any type of abuse. No other residents were identified as being abused and not reported.

On 11/9/2022 -11/10/22, all staff in all departments were interviewed by members of the interdisciplinary team (IDT) that consists of Administrator, DON, ADON, and Unit Managers to determine if any other resident may have been affected and if they had observed and not reported any abuse. No concerns identified.

·Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

On 11/9/22, the ADON was reeducated on how to respond to situations where potential abuse may have occurred to include assessing the situation, removing a potential perpetrator from the resident, and reporting to the DON and/or Administrator

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 11/17/2022

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
F 610	Continued From page 29	F 610		

On 11/8/22, the Administrator, DON, and Staff Development RN were also reeducated on all components of the facility's abuse policy and how to identify abuse by the Regional Director of Operations. Education included the definition of abuse, reporting requirements, the need to conduct a thorough investigation, and monitoring for psychosocial changes by qualified individuals, as well as immediately separating the victim from the alleged perpetrator.

On 11/9/22, after being reeducated as outlined above education for all staff was completed by the Staff Development RN. The education consisted of the following:
The definition of abuse and the need to immediately notify the Administrator or DON of all issues related to these infractions. If Administrator or DON are not present in facility, supervisors must be notified, and they must inform the Administrator or DON immediately in person or by phone
Staff members who observe situations of abuse should immediately intervene to prevent continued potential abuse to residents. The perpetrator should be removed from the situation and placed under 1:1 supervision by the immediate supervisor or designee until they can be removed from premises or restricting visitation for accused individuals not employed by the facility
Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing. The following information should be reported:
The name(s) of the resident(s) to which the abuse or suspected abuse occurred
The date and time that the incident occurred

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 11/17/2022

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
F 610	Continued From page 30	F 610		

Where the incident took place
The name(s) of the person(s) allegedly committing the incident, if known
The name(s) of any witnesses to the incident
The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.)
Any other information that may be requested by management.
The individual conducting the investigation will, as a minimum:
Review the completed documentation forms
Review the resident's medical record to determine events leading up to the incident
Interview the person(s) reporting the incident
Interview any witness to the incident
Interview the resident (as medically appropriate)
Interview the residents attending physician as needed to determine the resident ' s current level of functioning and cognitive condition
Interview staff members on all shifts who have had contact with the resident during the period of the alleged incident
Interview the resident's roommate, family members, and visitors
Interview other residents to whom the accused employee provides care of services; and
Review all events leading up to the alleged incident
Preserve all audio and video recordings of the incident (if applicable)
In effort to protect residents from abuse, education included identification strategies for signs and symptoms of abuse such as physical abnormality, withdrawal, loss of appetite, and general changes in patterns and psychosocial well-being
Also, in effort to provide protection from abuse, keeping residents engaged in their community, supporting primary caregivers by identifying

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	345080	A. BUILDING _____ B. WING _____	C 11/17/2022

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
F 610	Continued From page 31	F 610		

caregivers who appear stressed or need a break from working with difficult residents. (This situation should also be brought to the immediate attention of the supervisor.)
The fact that our facility does not condone and has zero tolerance for resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals.

This training will be provided by the Administrator or the Human Resource Director to all agency staff and new employees upon hire during orientation. All facility staff in all departments, including as-needed and agency staff, received this training on 11/8/22-11/9/22 and all staff will continue to receive the training yearly thereafter. The Administrator and Human Resource Director were notified by the Regional Director of Operations of the need to provide this training to new hires on 11/9/22.

Alleged IJ removal date is 11/10/22.

On 11/17/22 the credible allegation of immediate jeopardy with a removal date of 11/10/22 was validated through staff interview and review of in-service training records. Staff were able to verbalize the definitions of abuse and provided examples as well as vocalize they were to contact the Administrator or DON via phone or in person with any concerns of observed or reported potential of abuse. Staff reported they are to provide written statements of their observations or reports made by a resident, staff member, or family member to the facility Administrator immediately. Staff expressed knowledge that

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 11/17/2022

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
F 610	Continued From page 32 abuse is not tolerated and any staff member accused of abuse must be immediately removed from the facility while further evaluation is completed. Staff knew abuse allegations must be thoroughly investigated to include collecting written witness statements from all staff associated with allegation.	F 610		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		12/9/22

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 11/17/2022

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

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F 690	Continued From page 33 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to prevent a urinary catheter tubing and catheter bag from touching the floor for 1 of 1 resident (Resident #6) reviewed for urinary catheters. The finding included: Resident #6 was admitted to the facility on 12/21/21 with diagnoses that included neurogenic bladder. Resident #6's care plan revised on 03/29/22 indicated the Resident had an (indwelling urinary) catheter due to neurogenic bladder. The goal that the Resident would remain free from catheter related trauma would be attained by utilizing interventions such as anchoring catheter tubing to prevent pulling, checking tubing for kinks every shift and observe for and document signs and symptoms of pain or discomfort due to catheter. A further review of the updated care plan revised on 08/16/22 revealed Resident #6 was at risk for urinary tract infection (UTI) related to urinary catheter use. The goal for the Resident to remain free of infection would be attained by handwashing before delivery of care, observe for signs and symptoms of urinary infection and provide urinary catheter care as indicated. The quarterly Minimum Data Set (MDS)	F 690	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all the applicable state and federal regulatory requirements. Corrective action was accomplished for the alleged deficient practice when the facility failed to prevent catheter tubing/bag from touching the floor. On 11/7/22, the catheter was placed on wheelchair by the Nurse assigned to the hall. All residents with catheters are at risk from suffering from the deficient practice. On 11/7/22 an audit of all residents who have catheters was completed to ensure that catheter tubing and catheter bags are not touching the floor. None were found. All staff to include agency staff will be educated by the Director of Nursing (DON) or Designee on the need to keep catheter tubing/bags from touching the	

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	345080	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 690	Continued From page 34 assessment dated 08/01/22 revealed Resident #6 was moderately cognitively impaired, had no behaviors of rejection of care and had an indwelling urinary catheter. On 11/07/22 at 10:43 AM an observation was made of Resident #6 sitting in his wheelchair in the hallway. The Resident had a urinary catheter with the catheter tubing and the catheter bag touching the floor. On 11/07/22 at 11:14 AM a second observation was made of Resident #6 sitting in his wheelchair in the hallway. The Resident's urinary catheter tubing and catheter bag was touching on the floor. An observation was made on 11/07/22 at 2:10 PM of Resident #6 sitting in his wheelchair in the hallway with his urinary catheter tubing and catheter bag touching the floor. An interview was conducted with Nurse Aide (NA) #15 on 11/07/22 at 2:11 PM who confirmed she was responsible for Resident #6 during that shift. The NA acknowledged that the Resident's urinary catheter tubing and bag were on the floor and explained that the Resident "messes" with it all the time. The NA indicated the catheter bag and tubing should be anchored more securely to prevent it from touching the floor. An interview was conducted with Nurse #10 on 11/07/22 at 2:19 PM who observed Resident #6's urinary catheter bag and tubing on the floor and explained that the bag and tubing should be secured so that they did not touch the floor for infection control purposes. The Nurse repositioned the catheter bag to the right side of	F 690	floor by 12/1/2022. All new hires to include agency staff will be educated by the Director of Nursing (DON) or Designee moving forward on the need to keep catheter tubing/bags from touching the floor during orientation. The Director of Nursing/Designee will conduct weekly audits for (5) residents with catheters a week times (4) weeks, (3) residents with catheters a week times (4) weeks and (1) resident with a catheter a week times (4) weeks to assure catheter tubing and bags and free from touching the floor. The Director of Nursing/Designee will report the results of the audits in the facility's monthly QAPI meetings for (3) months and audits will continue at the discretion of the Quality Assurance Process Improvement (QAPI) committee. The Director of Nursing is responsible for implementing the corrective action. The facility will be in full compliance with this plan of correction no later than 12/9/2022	

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F 690	Continued From page 35 the wheelchair and off the floor and stated the Resident "played" with his catheter all the time and because of that the staff should keep a closer eye on the tubing and catheter to ensure they did not touch the floor. An interview was conducted with the Director of Nursing (DON) who functioned as the Infection Preventionist (IP) on 11/08/22 at 9:30 AM. The DON explained that Resident #6's catheter bag and tubing should be positioned below his bladder and off the floor to prevent urinary tract infections. The DON continued to explain that Resident #6 had a habit of "playing" with his catheter and because of that the staff should be more vigilant in making sure it was positioned correctly off the floor. During an interview with the Administrator on 11/09/22 at 2:51 PM he explained that the Director of Nursing made him aware of the issue with Resident #6's urinary catheter bag and tubing being on the floor. The Administrator stated it should not have been on the floor and the staff should have been making routine rounds to ensure the catheter bags and tubing were appropriately secured and positioned off the floor.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		12/9/22

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F 695	Continued From page 36 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview the facility failed to administer the prescribed rate of oxygen for 2 of 5 residents sampled for respiratory services. (Resident #51, #37). The findings included: 1. Resident #51 admitted to the facility on 01-14-21 with diagnoses that included acute respiratory failure with hypoxia (absence of enough oxygen in the blood to sustain bodily functions). Review of the quarterly Minimum Data Set (MDS) dated 10/10/22 indicated that Resident #51 was cognitively intact. The MDS further indicated that Resident #51 required oxygen and had shortness of breath with exertion and when lying flat. Review of active physician orders for November 2022 read, oxygen at 4 liters due to chronic respiratory failure with hypoxia, and auto continuous positive airway pressure (CPAP - for difficulty breathing during sleeping episodes) at bedtime with oxygen at 3 liters/minute. An observation and interview of Resident #51 was made on 11/07/22 at 10:35 AM. Resident #51 was lying in bed awake and verbal. The head of his bed was elevated approximately 15 degrees. He stated he was having no problems breathing. He was observed to have oxygen in place via nasal cannula at 3 liters/minute via concentrator next to his bed. He stated his oxygen should be at 4 liter/minute during the day.	F 695	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all the applicable state and federal regulatory requirements. Corrective action was accomplished for the alleged deficient practice when the facility failed to maintain correct Oxygen settings per physician orders. On 11/7/22 the Assistant Director of Nursing (ADON) verified acceptable oxygen levels for resident # 51 and adjusted the oxygen settings to the correct settings for resident #51 and the Director of Nursing (DON) verified acceptable oxygen levels for resident #37 and adjusted the oxygen settings to the correct settings for resident #37 All residents on Oxygen are at risk from suffering from the deficient practice. On 11/7/2022 and audit of all residents with oxygen was conducted to determine if oxygen was being provided at the correct liters per minute as prescribed by physician orders. No other concerns were identified.	

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F 695	Continued From page 37 An interview was conducted with Nurse # 11 on 11/07/22 at 10:40 AM. She stated she was not sure what the oxygen order was for Resident # 51. She stated she knew he was on CPAP at night, but when she arrived this morning his CPAP mask was already off. During an interview with the Assistant Director of Nursing (ADON) on 11/07/22 at 10:50 AM, the ADON verified Resident #51's oxygen order and confirmed it should be running at 4 liters/minute. She went to the resident's room and assessed him for any respiratory distress. She stated someone probably forgot to turn the oxygen back to 4 liter/minute when they took his CPAP off this morning. She stated at night on his CPAP his oxygen runs at 3 liters/minutes, but during the day without his CPAP his oxygen should be at 4 liters/minute. The ADON then changed the oxygen to 4 liter/minute. An observation of Resident #51 was conducted on 11/08/22 at 9:23 AM. The Resident was resting quietly with his eyes closed. The resident's oxygen was running at 4 liters/minutes via nasal cannula via concentrator at the bedside. A phone interview with Nurse # 7 was conducted on 11/09/22 at 9:03 AM. She stated she works the night shift and could not recall if resident had his CPAP mask on the early morning of 11/07/22 or if she removed it at the end of her shift. She stated she was aware the oxygen rate changed from 3 liters/minutes at night with his on CPAP on to 4 liters/minute in the day. An interview was conducted on 11/09/22 11:45 AM with the Director of Nursing (DON) and	F 695	All staff to include agency staff will be educated prior to working their next shift by the Director of Nursing or Designee on the need to confirm the Oxygen liters per minute settings are correct and set to the Physicians ordered settings by 12/1/2022. All new hires to include agency staff will be educated by the Director of Nursing or Designee moving forward on the need to confirm the Oxygen liters per minute settings are correct and set to the Physicians ordered settings during orientation. The Director of Nursing/Designee will conduct weekly audits for (5) residents using oxygen weekly for (4) weeks, (3) residents using oxygen weekly for (4) weeks and (1) resident using oxygen weekly for (4) weeks to assure Oxygen settings are correct and set per Physicians orders. The Director of Nursing/Designee will report the results of the audits in the facility's monthly QAPI meetings for (3) months and audits will continue at the discretion of the Quality Assurance Process Improvement (QAPI) committee. The Director of Nursing is responsible for implementing the corrective action. The facility will be in full compliance with this plan of correction no later than 12/9/2022	

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F 695	Continued From page 38	F 695		

Administrator. The DON stated it is her expectation that oxygen is administered per physician order. She stated she had discussed this with the provider, and they are going to change the order, so the oxygen rate is the same during day and night to avoid confusion.

2. Resident #37 admitted to the facility on 04/20/21 with diagnoses that included acute respiratory failure with hypoxia (absence of enough oxygen in the blood to sustain bodily functions) and asthma.

Review of the quarterly Minimum Data Set dated 08/23/22 indicated that Resident #37 was moderately cognitively impaired. The MDS further indicated that Resident #37 required oxygen and had shortness of breath with exertion and when lying flat.

Review of an active physician order for November 2022 read, oxygen at 3 liters due to chronic respiratory failure with hypoxia.

An observation and interview of Resident #37 was made on 11/07/22 at 1:00 PM. Resident #37 was lying in bed with eyes open. He was awake and able to answer basic questions. He was observed to have oxygen in place via nasal cannula at 2 liters via concentrator next to his bed. He was in no acute distress and stated he was having no problems breathing. The head of his bed was elevated approximately 15 degrees.

An observation of Resident #37 was made on 07/10/22 at 9:53 AM. Resident #37 was lying in bed with his eyes closed. He was observed to have oxygen in place via nasal cannula at 2 liters via concentrator next to his bed. He appeared to

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F 695	Continued From page 39 be resting comfortably and was not in any acute distress. An interview was conducted with Nurse # 11 on 11/07/22 at 1:07 PM. She stated she was not sure what the oxygen order was for Resident # 37. During an interview with the DON on 11/07/22 at 01:15 PM, the DON checked Resident #37's oxygen order and confirmed it should be running at 3 liters/minute. She went to the Resident's room and assessed him for any respiratory distress. The DON checked the resident's oxygen saturation (amount of oxygen in the blood) which was 95%. The DON then adjusted the oxygen flow to 3 liters/minute. During an interview with the DON and Administrator on 11/09/22 at 11:45 AM, the DON said it was her expectations that oxygen was administered per physician order.	F 695		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put	F 867	F690 related to Catheter Care has been implemented into the Quality Assurance and Performance Improvement Program All cited/identified deficient practices have	12/9/22

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F 867	Continued From page 40 into place following the recertification survey of 3/25/21. This was for one deficiency that was originally cited in March 2021 in the area of catheter care and was subsequently recited on the current recertification survey of 11/17/22. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: F690- Based on observations, record reviews and staff interviews, the facility failed to prevent a urinary catheter tubing and catheter bag from touching the floor for 1 of 1 resident (Resident #6) reviewed for urinary catheters. During the recertification and the complaint investigation survey completed on 3/25/21 the facility failed to obtain a physician's order for an indwelling catheter and failed to apply a stabilizing device for resident indwelling catheters for 3 of 3 resident reviewed for urinary catheters. An interview with the Administrator on 11/09/22 at 3:47 PM revealed when he arrived at the facility in April 2022, catheter care was not in the quality assurance program. He stated he was not sure why it failed and stated catheter care would be reimplemented into the facility's quality assurance program to stop the repeated deficiencies.	F 867	been identified as having the potential to be affected. Inservice/Education provided to the Quality Assurance and Performance Improvement Committee by the Regional Clinical Director related to the expectation/responsibility of the Quality Assurance and Performance Improvement Committee to develop and implement appropriate plans of action to correct identified quality deficiencies, and to monitor and evaluate effectiveness. Quality Assurance and Performance Improvement (QAPI) Monitoring Tool developed and implemented to ensure each identified area of deficient practice is reviewed in the monthly Quality Assurance and Performance Improvement Committee Meeting. The QAPI Monitoring Tool will include F600, F610, F690, and F695. The QAPI Monitoring Tool will be completed by the Administrator and presented in the monthly Quality Assurance and Performance Improvement Committee by the Administrator to ensure compliance and evaluate effectiveness. The QAPI Monitoring Tool will be completed monthly for a consecutive twelve (12) months to ensure compliance and evaluate effectiveness. The Administrator is responsible for implementing the corrective action. The facility will be in full compliance with	

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F 867	Continued From page 41	F 867	this plan of correction no later than 12/9/2022	