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 01/04/2023

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 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 12/29/22 through 1/4/23. The credible allegation of compliance was validated on 1/4/23. 1 of the 2 complaint allegations was substantiated resulting in deficiencies. The following intakes were investigated NC00195052 and NC00195296. Intake #NC00195296 resulted in immediate jeopardy. Event ID #WQDM11. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483. 12 at tag F684 at a scope and severity (J) The tags F600 and F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/22/22 and was removed on 1/1/23. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(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-	F 600		1/5/23

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

Electronically Signed | 01/23/2023

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 01/04/2023

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 1 §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 and family, nurse practitioner (NP), x-ray company representative and staff interviews, the facility neglected to provide necessary care and services after a resident complained of left lower pain during therapy on 11/22/22 and was assessed by the Physical Therapist who recommended an x-ray of Resident #1's left lower extremity and spine. The x-ray results reported on 11/23/22 noted an acute, transverse, displaced sub capital fracture of the femoral neck (a transverse break is usually associated with major force, displaced fracture typically required surgical intervention for repair, sub-capital meaning it occurred in the neck of the thigh bone). No facility staff followed up on or acknowledged the x-ray results. Resident #1 continued to report pain in his left lower extremity to therapy daily and on 11/25/22 refused therapy due to the severe pain. No medical evaluation or treatment were initiated until the Nurse Practitioner called the facility near midnight on 11/27/22 and reported the x-ray results to staff. Resident #1 reported left hip pain of 9 on a scale of 9 to 10 (10 being the worst pain) prior to being transferred to the hospital on 11/28/22 and the left hip fracture required surgical intervention for repair. This deficient practice occurred for 1 of 3 residents reviewed for professional standards (Resident #1). The Immediate Jeopardy (IJ) began on 11/22/22 when Resident #1 complained of significant lower extremity pain and no nursing or medical	F 600	F600 □ Freedom from Abuse, Neglect and Exploitation 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 completing an assessment and communicating to Nursing Administration and Physician extender residents□ pain and change in condition. All other residents experiencing pain or other signs of significant changes without an assessment and pending X-ray results are at risk of suffering from the deficient practice. On 12/30/22 □ 12/31/22, an audit of all residents was completed by the Unit Managers or designee to determine if they have experienced any pain or changes in condition without treatment and for residents with pending X-ray results. No concerns were found.	

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 01/04/2023

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 2 interventions were provided. The immediate jeopardy was removed on 1/1/23 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 complete education and to ensure monitoring systems are put into place are effective. Findings included: Resident #1 was admitted to the facility on 11/7/2022 for short term rehabilitation with diagnoses that included, unsteady on his feet, abnormal gait, and a history of falls. An admission Minimum Data Set (MDS) dated 11/14/22 indicted Resident #1 was cognitively intact for decision making and reflected no pain present. A physical therapy note dated 11/22/22 written by Physical Therapy Assistant (PTA) #1 revealed, on multiple days ranging from 11/22/22 through 11/25/22, Resident #1 had complained of pain in the left knee which radiated down the calf with certain movements. The note further explained PTA #1 notified both the PT and the Therapy Program Manager of Resident #1's change of condition. Which included an assessment by the PT of Trendelenburg gait with scissoring feet patterns with maximum assistance provided by staff, flexed posture, (a stepping pattern where the feet cross when attempting to move in a forward motion as well as where hips are flexed upward with each step) and LLE pain. The PT recommended an order for an x-ray to be obtained to the LLE and spine. The Nurse Practitioner wrote an order dated	F 600	On 12/30/22, education was provided to the Administrator by the Director of Operations regarding the definition of neglect. On 12/31/22 education was provided to the Human Resources Director by the Administrator regarding the definition of neglect and including education to all new hires/agency direct care staff during orientation. " The definition of neglect and the need to immediately notify the Administrator or Director of Nursing of all issues related to these infractions. If Administrator or Director of Nursing are not present in facility, supervisors must be notified, and they must inform the Administrator or Director of Nursing immediately in person or by phone. " Our facility does not condone and has zero tolerance for resident neglect 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. On 12/30/22-12/31/22, education was provided by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or designee to all care staff including CNA□s, Nurses, Therapists, and Nurse Practitioner regarding the definition of neglect, as defined in the neglect policy and the resident□s right to be free from neglect.	

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 01/04/2023

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 3 11/22/22 requesting an x-ray for the left hip and lumbar spine to be obtained for LLE pain and leg shortening. Medical record review revealed a physician's order dated 11/22/22 for an x-ray for the left hip and lumbar spine were to be obtained for LLE pain and leg shortening for Resident #1. An x-ray report dated 11/23/22 indicated Resident #1 had a radiological study of the left hip and lumbar spine on 11/22/22 which resulted with findings to include an acute, transverse, displaced sub capital fracture of the femoral neck. (a transverse break is usually associated with major force, displaced fracture typically required surgical intervention for repair, sub-capital meaning it occurred in the neck of the thigh bone). The x-ray was not signed by staff as being received. A review of the medical record of Resident #1 revealed no notification was made by facility staff to the medical provider regarding the results of Resident #1's x-ray performed on 11/22/22. A physical therapy note dated 11/23/22 written by PTA #1 revealed Resident #1 had increase confusion, continued with unsafe Trendelenburg gait with scissoring pattern, pain in the left knee which radiated into the calf. PTA #1's note indicated she notified nursing of Resident #1's condition and was told that an x-ray had been ordered the day before and the results were pending as well as she was requesting an order for a urinary analysis (UA) for increased confusion. An interview with PTA #1 on 12/30/22 at 11:00 AM	F 600	Neglect is defined as failure of the facility, it□s employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress. Staff to include the Nurse Practitioner was also educated 12/30/22-12/31/22 to immediately address pain, complete assessments and treat pain as directed by the Physician or Physician Extender (Nurse Practitioner). Director of Nursing/Assistant Director of Nursing/Unit Managers were educated on 11/28/22 regarding the process of tracking pending diagnostic orders until results are obtained. This process includes a diagnostics log implemented by the Director of Nursing utilizing the EMAR system to identify and document on the log all new orders created each day and reviewed by Director of Nursing/Assistant Director of Nursing/Unit Managers daily until results are obtained to ensure compliance and effectiveness. All staff, including agency staff will receive education prior to start of shift to include the definition of neglect and the abuse/neglect reporting requirements including immediate intervention. The Director of Nursing and Administrator will be responsible to ensure this is completed for all licensed staff members. The Director of Nursing/Designee will complete change of condition audits daily (5) five times a week for (4) four weeks, then (3) times a week for (4) weeks to	

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 01/04/2023

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 4 revealed she was familiar with Resident #1 and had worked with him on several days while in the facility. PTA #1 explained she had provided therapy treatment to Resident #1 on 11/22/22 when he reported pain in knee down to calf with certain movements. She indicated on 11/22/22 his gait was worse than his baseline and during ambulation he was moving his feet in a scissoring motion which made his safety compromised. She stated on that date, the Physical Therapist was assisting her with Resident #1's ambulation and performed a quick exam of him and thought he should receive radiological studies. PTA #1 stated both she and the PT made the Therapy Program Manager aware of Resident #1's condition being worsened and to her knowledge an x-ray was ordered on that date. PTA #1 stated she worked with Resident #1 again on 11/23/22 when she noticed he had increased confusion, continued to complain of LLE pain and ambulate in a scissoring gait fashion. PTA #1 indicated she spoke with the nurse on the unit; however, she could not recall which nurse, and was told an x-ray had been ordered but the result was not available at the time and the nurse would request an order for a urinary analysis if the confusion continued. PTA #1 stated that was the last day she worked with Resident #1 because he was discharged from therapy services when he was sent to the hospital for a fractured hip. A telephone interview with the Physical Therapist on 12/30/22 at 1:20 PM revealed she had evaluated Resident #1 on admission and had provided therapy treatment on several days during his stay at the facility. She explained Resident #1 began having periodic vague complaints of pain beginning with his wrist about a week after admission; however, she noticed	F 600	ensure there are no new residents experiencing pain or other signs of significant changes without an assessment and pending X-ray results . The Director of Nursing will be responsible for implementing the corrective action. The facility will be in full compliance with this Plan of Correction no later than 1/5/23	

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 01/04/2023

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 5	F 600		

acute changes to Resident #1 on 11/18/22 and the pain to his LLE progressively got more intense over the remainder of his stay in the facility. The PT stated she had performed a couple brief tests on Resident #1 when she initially thought there was a possibility of nerve impingement or a possible blood clot due to pain in the knee with weight bearing and abnormal gait, but the test was not abnormal and therefore notified the Therapy Program Manager with recommendations of radiological studies. The PT could not recall whether Resident #1's leg lengths varied, but stated she allowed Resident #1 to continue therapy while x-rays were pending because he continued to actively participate in spite of some reports of pain. She indicated she had asked a hall nurse, although unable to identify which nurse, about the x-ray results but were told they remained pending.

An interview with the Therapy Program Manager on 12/30/22 at 11:50 AM revealed she was the Therapy Program Manager and had not directly worked with Resident #1; however, had been made aware of his complaints of pain to his LLE and abnormal gait. She stated on 11/22/22 she had been made aware of the concerns with his change in condition and she had made the Unit Manager aware of the recommendation to obtain a radiological study to determine the changes noticed during therapy. She further stated she was later made aware an x-ray had been ordered but was not aware of the results of a hip fracture until she arrived at the facility on 11/28/22 and learned Resident #1 had been admitted to the hospital.

An interview with Nurse #4 on 12/30/22 at 12:15 PM revealed she was one of the day 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 01/04/2023

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 6	F 600		

Supervisors/Unit Manager in the facility and was the one who obtained the order the NP for Resident #1 to have radiological studies of the left hip and spine on 11/22/22 and called the local x-ray company to setup the appointment to have them completed. Nurse #4 indicated when she was notified by therapy of Resident #1's change of condition to include pain in his LLE and therefore proceeded to obtain orders. Her normal process was to inform the nurse assigned to the unit of the resident's orders or changes in condition; however, she could not recall who she informed on 11/22/22 of the orders for the radiological studies or the concerns with changes in therapy and she did not perform a physical assessment of Resident #1 at the time, but strictly requested the x-ray as a recommendation of therapy staff. Nurse #4 further stated after studies were completed, the results were faxed to the facility, and they typically receive a phone call alerting them of abnormal results; however, she could not recall why results were not available for Resident #1's studies during the typical range of 24 hours after the x-ray was obtained. She stated she had not contacted the x-ray company herself to verify the result following the order being made on 11/22/22.

An interview with the Nurse Practitioner on 12/30/22 at 10:36 AM revealed she was the facility's routine NP. The NP stated she recalled Resident #1 and being informed on 11/22/22 by a staff member that requested x-rays for Resident #1 due to complaints of LLE pain and leg shortening. The NP reviewed her documentation in Resident #1's medical record and stated she had recorded a visit on 11/22/22 for a medication review; however, had not included any documentation related to the complaints of pain

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 01/04/2023

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 7	F 600		

nor leg shortening. The NP stated if she had assessed Resident #1 after the request of the orders, an addendum would have been included in her note on 11/22/22. The NP stated she was not on duty during the period of 11/23/22 through 11/28/22 due to the holidays; however, late on the evening of 11/27/22 she was reviewing the medical record of Resident #1 and discovered the x-ray results which revealed a left hip fracture. She called the facility on 11/28/22 to see if Resident #1 had returned to the facility and nursing staff that answered the phone had no knowledge of the x-ray results. The NP stated she would expect the facility to inform a provider of all abnormal x-ray results immediately and did not feel as though the delay from 11/22/22 through 11/27/22 was an appropriate length of time for Resident #1 to go without medical intervention for a hip fracture. The NP indicated the facility had on-call services 24/7 for notification of abnormal results and orders. The NP also indicated she was not aware Resident #1 went without any pain management from 11/22/22 through 11/28/22. The NP indicated she was not an expert with orthopedics and could not specify how the injury occurred; however, stated it may have been possible the injury occurred because of an undetected hairline fracture which crumbled with increase weight bearing activities resulting in a complete break in a short period of time. The NP said because she did not assess him, she could not speak to his leg shortening or treatment plan other than she ordered the x-ray.

A physical therapy note dated 11/24/22 written by the PT indicated Resident #1 had reported continued pain to his LLE and nursing was made aware and informed therapy the pain was related to arthritic changes. The PT could not verify

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 01/04/2023

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 8	F 600		

which nurse she made aware.

A physical therapy note dated 11/25/22 written by PTA #2 indicated Resident #1 refused to participate in ambulation exercises in therapy due to having pain in the LLE. The hall nurse (Nurse #7) was notified of the ongoing concern at the time.

Attempts to interview PTA #2 were unsuccessful.

Attempts to interview Nurse #7 were unsuccessful.

A review of Resident #1's medical record revealed no notes reflected a comprehensive pain assessment was completed besides what is listed on the MAR following the complaints made in therapy.

A review of the November 2022 Medication Administration Record (MAR) revealed Resident #1 received scheduled Tylenol 1000 mg (milligrams) every 8 hours from 11/15/22 through 11/22/22 for joint pain. Resident #1 did not receive any additional pain medication for reported pain in therapy and mild complaints of pain to nursing staff from the evening of 11/22/22 through the morning of 11/28/22 at 12:12 AM when he received a time order for Norco 5/325 mg and Tylenol 1000 mg to be administered before transferring him to the emergency room (ER) for evaluation of a left hip fracture.

The November MAR (Medication Administration Record) had pain documented as follows: 11/8 pain level #1, 11/12 pain level #2 on days and level #1 on 2nd. No further pain was documented until 11/22 with level #1 on both 1st and 2nd.

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 01/04/2023

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 9	F 600		

11/25 level #3 on days and level #2 on 2nd. Additionally, on 11/26 Resident #1 reported pain level #1 on 1st and 2nd and on 11/27 level #2 on 1st and level #3 on 2nd.

A physician's order entered by Nurse #3 on 11/28/22 at 12:07 AM indicated the following: Tylenol 500 mg (2 tablets) x 1 dose NOW and Norco 5/325 mg NOW for pain.

An Interact note (change of condition form) written by Nurse #1 dated 12/28/22 indicated Resident #1 was discharged to the hospital for an abnormal x-ray with a pain level #9 to the left hip. He was then transferred and the next of kin (Kim Whitener- niece) was notified of transfer.

A nurses note dated 11/28/22 written by Nurse #1 indicated the hospital called to question the facility regarding the x-ray, fracture, and delayed treatment for 6 days and the nurse had no knowledge of the x-ray, or any concerns related the resident until that shift.

An Emergency Room report dated 11/28/22 indicated the hospital had contacted the facility about the delay in treatment following the x-ray performed on 11/22/22 and was told "he slipped through the cracks" and therefore the results were not interpreted, nor treatment initiated for 6 days following the studies due to the provider being on vacation. The report further indicated Resident #1 had a displaced and impacted left femoral neck fracture and recommended a CT (computer tomography study- a more detailed radiological study where a computer guides the x-ray).

A hospital History and Physical dated 11/28/22

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 01/04/2023

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		

indicated Resident #1 was admitted to the hospital with a fracture to the left hip with orthopedic and vascular surgery pending.

A telephone interview with a Dispatcher from X-ray company on 12/29/22 at 3:08 PM revealed the documentation provided in their records indicated Resident #1 had a radiological order for a left hip and lumbar spine studies which were obtained by staff on 11/22/22 at 11:55 PM and resulted in an acute, transverse, displaced, subcapital fracture of the femoral neck on 11/23/22 at 1:55 AM. The dispatcher indicated results had been faxed to the facility and a call placed to the facility; however, the notes did not include who the Dispatcher spoke with at the time of the call and no further details were included in this record for this study.

A telephone interview with Nurse #1 on 12/30/22 at 9:40 AM revealed she was the nurse who was on duty on both the evening of 11/22/22 and the evening of 11/27/22 and typically worked 7:00 PM-7:00 AM shifts. Nurse #1 indicated she was not informed during shift-to-shift report that an order was obtained on 11/22/22 for Resident #1 to have radiological studies performed, that he had complained of pain, nor whether radiological studies had been performed at the time. She did not recall him complaining of pain and she did not assess him. Nurse #1 also indicated she was on duty on the evening of 11/27/22 when she received a phone call very late in the shift from the facility's nurse practitioner (NP) questioning Resident #1's condition due to the x-ray results she reviewed in his medical record of the fracture, and to see if he was at the hospital. Nurse #1 stated she requested assistance from another nurse on duty at the time (Nurse #2) to

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 01/04/2023

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 11	F 600		

help locate the radiological studies performed on Resident #1 on 11/22/22 and found the report revealed an acute, transverse, displaced subcapital fracture of the femoral neck. Nurse #1 stated she and Nurse #2 went to Resident #1's room during the phone call and asked him about his pain and was told he had some pain at the time. Nurse #1 did not recall if she performed any physical assessment for Resident #1 other than asked him about his pain. Nurse #1 indicated both she and Nurse #2 returned to the telephone and received orders from the NP to provide pain medications and send Resident #1 to the ER immediately for evaluation. Nurse #1 stated she collected needed paperwork while Nurse #2 called Emergency Medical Services to the facility.

A telephone interview with Nurse #2 on 12/30/22 at 9:49 AM revealed she was on duty on the evening shift (7:00 PM to 7:00 AM) on 11/27/22 and recalled Nurse #1 asked her to help her find x-ray results that were ordered by the NP on 11/22/22. Nurse #2 stated after some difficulty, she was able to locate the results for Resident #1's studies which revealed Resident #1 had sustained an acute, transverse, displaced subcapital fracture of the femoral neck. Nurse #2 stated the NP became upset and questioned why Resident #1 was still in the facility at the time with a fractured hip. Nurse #2 stated she had not provided direct care to Resident #1 during that timeframe and had no knowledge of the studies being ordered or why interventions had not been placed for the left hip fracture until that time. Nurse #2 stated she, Nurse #1, and the night shift supervisor (Nurse #3) all went to Resident #1's room that night after receiving the phone call from the NP and stated Resident #1 complained of back and hip pain at the time. Nurse #2 did not

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 01/04/2023

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 12	F 600		

recall if she performed any physical assessment for Resident #1 other than asked him about his pain. Nurse #2 stated she called EMS to transfer Resident #1 to the emergency room for evaluation immediately.

A telephone interview with Nurse #3 on 12/30/22 at 9:59 AM revealed she was the supervisor on duty on the evening of 11/27/22 when Nurse #1 and Nurse #2 gained knowledge of radiological studies for Resident #1 which included a left hip fracture. Nurse #3 indicated she had worked several days during the timeframe of 11/22/22 through 11/27/22 and had no knowledge Resident #1 had x-rays ordered and resulted in a hip fracture. Nurse #3 stated she did not provide direct care for Resident #1 and could not address pain management during that time. Nurse #3 stated when results were received from the x-ray company, all abnormalities were to be immediately called to the provider, the copies placed in the provider's binder located at the nurses' station and the on-coming nurses to receive report of any pending x-ray results.

An interview with Nurse #5 on 12/30/22 at 12:00 PM revealed she had worked with Resident #1 during his stay; however, could not verify which dates. Nurse #5 indicated she recalled being notified by a member of therapy that he had complained of pain during his treatment and had some slight swelling in his lower extremity. Nurse #5 stated therapy had placed him back in bed and offloaded his LLE's and she asked the Unit Manager about the x-ray results since she was unable to locate them in his medical record. According to Nurse #5, she was told by the Unit Manager that the results were still pending, and she thought she gave him pain medication but

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 01/04/2023

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 13	F 600		

stated if it was not listed on the MAR she may have been waiting for an order for additional medication at the time if none was ordered.

A telephone interview with Nurse #6 on 12/30/22 at 12:45 PM revealed she was familiar of Resident #1, however, she could not recall the x-ray being ordered even though she was on duty when the x-ray was obtained, she had no knowledge of what time it was obtained and at no time looked for a result or performed a physical exam of Resident #1 secondary to his pain or LLE shortening. Nurse #6 did not recall him being in pain.

An interview with the Director of Nursing (DON) on 1/4/22 at 10:30 AM revealed she had become aware of Resident #1's x-ray which resulted in a left hip fracture when she arrived at the facility on 11/28/22 and was notified he had been admitted to the hospital. The DON further explained typically all x-ray reports are obtained within 24 hours following the x-ray being performed but could not explain why staff had not contacted the imaging company when the results continued to be pending after 24 hours nor why no formal assessment of the ongoing complaints of pain or potential LLE shortening had been performed as these would be expected to be included in the medical record with any acute change in condition.

The Administrator was notified of immediate jeopardy via telephone on 12/30/22 at 5:20 PM.

F600
o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

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 01/04/2023

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 14	F 600		

* On 11/22/22 the facility neglected to provide services in accordance with resident's physical needs upon exhibiting a significant change of condition related to pain.
On 11/22/22, documentation mentioned possible shortening of the leg

* On 11/22/22 resident #1 had swelling and redness of LLE. X-Ray was ordered and results identified on 11/28/22 at which time it was discovered to be a fracture. The delay in review of the X Ray was a result of lack of a process to track pending X Ray Results. During that time the patient experienced pain and confusion with no assessment or pain medication administered.

*All other residents experiencing pain or other signs of significant changes without an assessment and pending x-ray results are at risk from suffering from the deficient practice.

On 12/30/22 - 12/31/22, an audit of all residents was completed by the Unit Managers or designee to determine if they have experienced any pain or changes in condition without treatment and for residents with pending x-ray results. 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

On 12/30/22 education was provided to the Administrator by the Director of Operations regarding the definition of neglect.

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 01/04/2023

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 15 On 12/31/22 education was provided to the Human Resources Director by the Administrator regarding the definition of neglect and including education to all new hires/Agency direct care staff during orientation. " The definition of neglect 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 " Our facility does not condone and has zero tolerance for resident neglect 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. 0n 12/30/22 - 12/31/22, education was provided by the DON, ADON, Unit Managers or designee, to all care staff to include CNA's, Nurses, Therapist, and Nurse Practitioner regarding the definition of neglect, as defined in the neglect policy and the resident's right to be free from neglect. "Neglect" is defined as failure of the facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress. Staff, to include the Nurse Practitioner was also educated 12/30/22 - 12/31/22 to immediately address pain, complete assessments and treat	F 600		

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 01/04/2023

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 16	F 600		

pain as directed by the Physician or Physician Extender (Nurse Practitioner). DON/ADON/Unit Mangers were educated on 11/28/22 regarding the process of tracking pending diagnostic orders until results are obtained. This process includes a diagnostics log implemented by the DON utilizing the EMAR system to identify and document on the log all new orders created each day and reviewed by DON/ADON/Unit Managers daily until results are obtained to ensure compliance and effectiveness. All staff, including agency staff will receive education prior to the start of the shift to include the definition of neglect and the abuse/neglect reporting requirements including immediate intervention. The Director of nursing and administrator will be responsible to ensure this is completed for all licensed staff members

On 12/30/22 - 12/31/22, after being reeducated as outlined above, education for all direct care staff to include the Nurse Practitioner was completed in person and via phone by the DON, ADON, Unit Managers or Designee. The education consisted of the following:

" The definition of neglect 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 neglect and mental anguish such as loss of interest, change in routine, change of condition (specifically related to pain), mood alterations, or difficulty eating.

" Our facility does not condone and has zero tolerance for resident neglect by anyone,

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 01/04/2023

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 17 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 changes in condition, specifically related to pain and to ensure x-ray results were received and reported. 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 direct care staff including as-needed and agency staff, received this training on 12/30/22 - 12/31/22 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 12/30/22. Alleged IJ removal date is 1/1/23. The credible allegation with an IJ removal date of 1/1/23 was validated on 1/4/23. Staff were able to verbalize the definitions of neglect 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 neglect. Staff report 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 vocalized and demonstrated the updated processes for obtaining and reporting results to a provider and documentation required with all acute changes to a resident.	F 600		
F 684 SS=J	Quality of Care	F 684		1/5/23

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 01/04/2023

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 684	Continued From page 18 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, and family, Nurse Practitioner, x-ray company representative, and staff interviews, the facility failed to provide comprehensive assessments for a resident when the Unit Manager and Nurse Practitioner were made aware the resident had complaints of lower left extremity pain on 11/22/2022 and was noted to have shortening of his left leg by therapy. An x-ray was ordered on 11/22/22 with results reported to the facility on 11/23/22, which noted an acute, transverse, displaced left femoral neck fracture (a transverse break is usually associated with major force, displaced fracture typically required surgical intervention for repair, sub-capital meaning it occurred in the neck of the thigh bone). The x-ray results were not followed up on or acknowledged after the x-ray was completed and the resident continued to report pain during therapy. No medical evaluation or treatment were initiated until the Nurse Practitioner called the facility near midnight on 11/27/22 and reported the x-ray results to staff. Resident #1 reported left hip pain of 9 on a scale of 9 to 10 (10 being the worst pain) prior to being transferred to the hospital on 11/28/22 and the left hip fracture required surgical intervention for	F 684	F684 □ Quality of Care 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 completing a comprehensive assessment and note a significant change in condition in resident delaying the medical intervention and treatment including pain interventions for the resident. All other residents experiencing pain or other signs of significant changes without an assessment and pending X-Ray results are at risk of suffering from the deficient practice.	

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 01/04/2023

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 684	Continued From page 19 repair. This deficient practice occurred for 1 of 3 residents reviewed for professional standards (Resident #1). The Immediate Jeopardy (IJ) began on 11/22/22 when Resident #1 complained of significant lower extremity pain and experienced changes in his gait during therapy and assessments and interventions were not provided. The immediate jeopardy was removed on 1/1/23 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 complete education and to ensure monitoring systems are put into place are effective. Findings included: Resident #1 was admitted to the facility on 11/7/2022 for short term rehabilitation with diagnosis that included, unsteadiness of his feet, vascular dementia, abnormal gait, and a history of falls. An admission Minimum Data Set (MDS) dated 11/14/22 indicted Resident #1 was cognitively intact for decision making and reflected no pain present. A physical therapy note dated 11/18/22 written by the Physical Therapist (PT) indicated Resident #1 complained of left knee pain with movement which was reduced when at rest as well as swelling of the knee was noted upon examination. The note further indicated the Therapy Program Manager notified nursing staff of the change in Resident #1's condition.	F 684	On 11/28/22-11/30/22, the deficient practice was identified, and a self-imposed plan of correction was initiated. The facility retains compliance as it related to the monitoring of X-rays. All other residents were assessed for undocumented, unreported or unknown changes in condition that would result in a change in the resident plan of care including physician notification, thorough assessment and medical intervention by Unit Managers or designee on 12/30/22-12/31/22. No other residents were identified. On 11/28/22 an audit of all X-Rays ordered in the last 14 days was completed, no concerns were found. On 11/28/22 education was provided to all Nurses by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or designee on reporting of all ordered X-Ray results immediately to Director of Nursing or designee. On 11/28/22 Director of Nursing requested a Plan of Correction from the X-Ray provider in relation to no verbal notification of acute X-Ray findings as well as correction of fax number and creation of a pop-up screen with Director of Nursing contact information when no answer at the facility to assure notification. On 11/28/22 and ongoing, all X-Rays will be reported to the Director of Nursing or	

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 01/04/2023

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 684	Continued From page 20 A physical therapy note dated 11/22/22 written by Physical Therapy Assistant #1 (PTA) indicated Resident #1 had complained of pain in the left knee which radiated down the calf with certain movements. The note further explained PTA #1 notified both the Physical Therapist (PT) and the Therapy Program Manager of Resident #1's change of condition. The assessment by the PT was conducted which revealed Resident #1 had Trendelenburg gait with scissoring feet patterns with maximum assistance provided by staff (a stepping pattern where the feet cross when attempting to move forward and hips flex upward with each step), flexed posture, and LLE pain. The PT recommended an order for an x-ray to be obtained to the LLE and spine. The Nurse Practitioner wrote an order dated 11/22/22 requesting an x-ray for the left hip and lumbar spine to be obtained for LLE pain and leg shortening. An x-ray report dated 11/23/22 indicated Resident #1 had a radiological study of the left hip and lumbar spine on 11/22/22 which resulted with findings to include an acute, transverse, displaced sub capital fracture of the femoral neck. (a transverse break is usually associated with major force, displaced fracture typically required surgical intervention for repair, sub-capital meaning it occurred in the neck of the thigh bone). The x-ray was not signed by staff as being received. A review of the medical record of Resident #1 revealed no notification was made by facility staff to the medical provider regarding the results of Resident #1's x-ray performed on 11/22/22.	F 684	designee when ordered and will be followed up daily until results are received. X-Rays will be listed and monitored on a whiteboard each morning during morning meeting as well as the Nurse Manager office and documented on an audit form until results are received. The Director of Nursing was educated on 12/30/22 by the Regional Clinical Director. Education provided was specifically related to the change of condition (specifically related to pain) and the new process of tracking pending diagnostics tracking log to ensure compliance and effectiveness. The Assistant Director of Nursing and Unit Managers were educated by the Director of Nursing on 12/30/22. Education provided was specifically related to change of condition (specifically related to pain) and the new process of tracking pending diagnostics tracking log to ensure compliance and effectiveness. On 12/30/22-12/31/22 all direct care staff were educated to include Therapy staff by the Director of Nursing, Assistant Director of Nursing, Unit Managers or designee to immediately report changes in condition (specifically related to pain, including changes in appearance of the human anatomy) including change in behavior, ADL, or participation in activities, therapy or other usual patterns to licensed nurses. This education including verbal indications as well as non-verbal indications including grimacing, withdrawing, mental status changes, etc. for those residents who may	

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 01/04/2023

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 684	Continued From page 21 A physical therapy note dated 11/23/22 written by PTA #1 revealed Resident #1 had increase confusion, continued with unsafe Trendelenburg gait with scissoring pattern, pain in the left knee which radiated into the calf. PTA #1's note indicated she notified nursing of Resident #1's condition and was told that an x-ray had been ordered the day before and the results were pending as well as she was requesting an order for a urinary analysis (UA) for increase confusion. An interview with PTA #1 on 12/30/22 at 11:00 AM revealed she was familiar with Resident #1 and had worked with him on several days while in the facility. PTA #1 explained she had provided therapy treatment to Resident #1 on 11/22/22 when he reported pain in knee down to calf with certain movements. She indicated on 11/22/22 his gait was worse than his baseline and during ambulation he was moving his feet in a scissoring motion which made his safety compromised. She stated on that date, the Physical Therapist was assisting her with Resident #1's ambulation and performed a quick exam of him and thought he should receive radiological studies. PTA #1 stated both she and the PT made the Therapy Program Manager aware of Resident #1's condition being worsened and to her knowledge an x-ray was ordered on that date. PTA #1 stated she worked with Resident #1 again on 11/23/22 when she noticed he had increased confusion, continued to complain of LLE pain and ambulate in a scissoring gait fashion. PTA #1 indicated she spoke with the nurse on the unit; however, she could not recall which nurse, and was told an x-ray had been ordered but the result was not available at the time and the nurse would request an order for a urinary analysis if the confusion continued. PTA #1 stated that was the last day	F 684	not be able to verbalize a change in condition including but not limited to increased pain. Nurse Practitioner was educated on the expectation and importance of completing assessments when notified of change in condition and/or pain. All licensed nurses working and the Nurse Practitioner were educated on thorough assessments related to change in condition and/or pain; and reporting to Physician or Physician Extender (Nurse Practitioner) immediately on 12/30/22-12/31/22 by Director of Nursing, Assistant Director of Nursing, Unit Manager or designee. All other licensed staff members who were not present, including agency staff, new hires and new agency staff will receive education and training by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or designee to include above information prior to returning to work. The Director of Nursing/Designee will complete change of condition audits daily (5) five times a week for (4) four weeks, then (3) times a week for (4) weeks to ensure no new residents are experiencing pain or other signs of significant changes without an assessment and pending X-ray results. The Director of Nursing will be responsible for implementing the corrective action. The facility will be in full compliance with	

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 01/04/2023

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 684	Continued From page 22	F 684		

she worked with Resident #1 because he was discharged from therapy services when he was sent to the hospital for a fractured hip.

A telephone interview with the Physical Therapist on 12/30/22 at 1:20 PM revealed she had evaluated Resident #1 on admission and had provided therapy treatment on several days during his stay at the facility. She explained Resident #1 began having periodic vague complaints of pain beginning with his wrist about a week after admission; however, she noticed acute changes to Resident #1 on 11/18/22 and the pain to his LLE progressively got more intense over the remainder of his stay in the facility. The PT stated she had performed a couple brief tests on Resident #1 when she initially thought there was a possibility of nerve impingement or a possible blood clot due to pain in the knee with weight bearing and abnormal gait, but the test was not abnormal and therefore notified the Therapy Program Manager with recommendations of radiological studies. The PT could not recall whether Resident #1's leg lengths varied, but stated she allowed Resident #1 to continue therapy while x-rays were pending because he continued to actively participate despite some reports of pain. She indicated she had asked a hall nurse, although unable to identify which nurse, about the x-ray results but were told they remained pending.

An interview with the Therapy Program Manager on 12/30/22 at 11:50 AM revealed she is the Therapy Program Manager and had not directly worked with Resident #1; however, had been made aware of his complaints of pain to his LLE and abnormal gait. She stated on 11/22/22 she had been made aware of the concerns with his

this Plan of Correction no later than 1/5/23.

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 01/04/2023

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 684	Continued From page 23	F 684		

change in condition and she had made the Unit Manager aware of the recommendation to obtain a radiological study to determine the changes noticed during therapy. She further stated she was later made aware an x-ray had been ordered but was not aware of the results of a hip fracture until she arrived at the facility on 11/28/22 and learned Resident #1 had been admitted to the hospital.

A physical therapy note dated 11/24/22 written by PTA #2 indicated Resident #1 had reported continued pain to his LLE and nursing was made aware which informed therapy the pain was related to arthritic changes.

A physical therapy note dated 11/25/22 written by PTA #2 indicated Resident #1 refused to participate in ambulation exercises in the therapy pain secondary to ongoing pain in the LLE. The hall nurse was notified of the ongoing concern at the time.

A review of the November 2022 Medication Administration Record (MAR) revealed Resident #1 received no medications for pain from 11/22/22 through 11/27/22. On 11/28/22 at 12:12 AM, received a 1-time order for Norco 5/325 mg and Tylenol 1000 mg which was administered before transferring him to the emergency room (ER) for evaluation of a left hip fracture.

The November MAR (Medication Administration Record) had pain documented as follows: 11/8 pain level #1, 11/12 pain level #2 on days and level #1 on 2nd. No further pain was documented until 11/22 with level #1 on both first and second shifts, 11/25 level #3 on days and level #2 on second shift. Additionally, on 11/26 Resident #1

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 01/04/2023

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 684	Continued From page 24	F 684		

reported pain level #1 on first and second shift and on 11/27 level #2 on first shift and level #3 on second shift.

A physician's order entered by Nurse #3 on 11/28/22 at 12:07 AM indicated the following: Tylenol 500 mg (2 tablets) x 1 dose NOW and Norco 5/325 mg NOW for pain.

A review of Resident #1's medical record revealed no notes reflected a comprehensive pain assessment to include LE shortening was completed besides every shift pain levels routinely listed on the MAR following the complaints made in therapy on 11/22/22.

An Interact note (change of condition form) written by Nurse #1 dated 11/28/22 indicated Resident #1 was discharged to the hospital for an abnormal x-ray with a pain level #9 to the left hip.

A nurses note dated 11/28/22 written by Nurse #1 indicated the hospital called to question the facility regarding the x-ray, fracture, and delayed treatment for 6 days and the nurse had no knowledge of the x-ray, or any concerns related the resident until that shift.

A hospital History and Physical dated 11/28/22 indicated Resident #1 arrived in the ER via EMS on 11/28/22 after it was discovered by the facility, he had a left femoral neck fracture after the x-ray ordered on 11/22/22 had not been reviewed until then. During the ER exam, the fracture of the left femur was confirmed, and Resident #1 was admitted to the hospital with a fracture to the left hip with orthopedic and vascular surgery pending.

An Emergency Room report dated 11/28/22

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 01/04/2023

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 684	Continued From page 25	F 684		

indicated the hospital had contacted the facility about the delay in treatment following the x-ray performed on 11/22/22 and was told "he slipped through the cracks" and therefore the results were not interpreted, nor treatment initiated for 6 days following the studies due to the provider being on vacation. The report further indicated Resident #1 had a displaced and impacted left femoral neck fracture and recommended a CT (computer tomography study- a more detailed radiological study where a computer guides the image).

An interview with the Nurse Practitioner on 12/30/22 at 10:36 AM revealed she was the facility's routine NP. The NP stated she recalled Resident #1 and being informed on 11/22/22 by a staff member that requested x-rays for Resident #1 due to complaints of LLE pain and leg shortening. The NP reviewed her documentation in Resident #1's medical record and stated she had recorded a visit on 11/22/22 for a medication review; however, had not included any documentation related to the complaints of pain nor leg shortening. The NP stated if she had assessed Resident #1 after the request of the orders, an addendum would have been included in her note on 11/22/22. The NP stated she was not on duty during the period of 11/23/22 through 11/28/22 due to the holidays; however, late on the evening of 11/27/22 she was reviewing the medical record of Resident #1 and discovered the x-ray results which revealed a left hip fracture. She called the facility on 11/28/22 to see if Resident #1 had returned to the facility and nursing staff that answered the phone had no knowledge of the x-ray results. The NP stated she would expect the facility to inform a provider of all abnormal x-ray results immediately and did

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 01/04/2023

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 684	Continued From page 26	F 684		

not feel as though the delay from 11/22/22 through 11/27/22 was an appropriate length of time for Resident #1 to go without medical intervention for a hip fracture. The NP indicated the facility had on-call services 24/7 for notification of abnormal results and orders. The NP also indicated she was not aware Resident #1 went without any pain management from 11/22/22 through 11/28/22. The NP indicated she was not an expert with orthopedics and could not specify how the injury occurred; however, stated it may have been possible the injury occurred because of an undetected hairline fracture which crumbled with increase weight bearing activities resulting in a complete break in a short period of time. The NP said because she did not assess him, she could not speak to his leg shortening or treatment plan other than she ordered the x-ray. The NP could not recall why Resident #1 was not assessed and generally stated she could have been leaving or something other patient care when staff approached her but could not specifically recall why she did not assess him before giving the orders.

An interview with a dispatcher from x-ray company on 12/29/22 at 3:08 PM revealed the documentation provided in their records indicated Resident #1 had a radiological order for a left hip and lumbar spine studies which were obtained by staff on 11/22/22 at 11:55 PM and resulted in an acute, transverse, displaced, subcapital fracture of the femoral neck on 11/23/22 at 1:55 AM. The dispatcher indicated results had been faxed to the facility and a call placed to the facility; however, the notes included did not include who the dispatcher spoke with at the time of the call and no further details were included in this record for this study.

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 01/04/2023

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 684	Continued From page 27	F 684		

An interview with Nurse #1 on 12/30/22 at 9:40 AM revealed she was the nurse who was on duty on both the evening of 11/22/22 and the evening of 11/27/22 and typically worked 7P-7A shifts. Nurse #1 indicated she was not informed during shift-to-shift report that an order was obtained on 11/22/22 for Resident #1 to have radiological studies performed, that he had complained of pain, nor whether radiological studies had been performed at the time. Nurse #1 also indicated she was on duty on the evening of 11/27/22 when she received a phone call very late in the shift from the facility's nurse practitioner (NP) questioning Resident #1's condition and if he was at the hospital. When Nurse #1 asked further questions Nurse #1 was unable to answer, Nurse #1 stated she requested assistance from another nurse on duty at the time (Nurse #2) who was able to locate the radiological studies performed on Resident #1 on 11/22/22 resulted in an acute, transverse, displaced subcapital fracture of the femoral neck. Nurse #1 stated she and Nurse #2 went to Resident #1's room during the phone call and asked him about his pain and was told he had some pain at the time. Nurse #1 did not recall if she performed any physical assessment for Resident #1 other than asked him about his pain. Nurse #1 indicated both she and Nurse #2 returned to the telephone and received orders from the NP to provide pain medications and send Resident #1 to the ER immediately for evaluation. Nurse #1 stated she collected needed paperwork while Nurse #2 called paramedics (EMS) to the facility.

An interview with Nurse #2 on 12/30/22 at 9:49 AM revealed she was on duty on the evening shift (7P-7A) of 11/27/22 when Nurse #1 asked her to

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 01/04/2023

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 684	Continued From page 28	F 684		

aid when the facility's NP called asking questions about an x-ray, she had ordered on 11/22/22. Nurse #2 stated after some difficulty, she was able to locate the results for Resident #1's studies which revealed Resident #1 had sustained an acute, transverse, displaced subcapital fracture of the femoral neck. Nurse #2 stated the NP became upset and questioned why Resident #1 was still in the facility at the time with a fractured hip. Nurse #2 stated she had not provided direct care to Resident #1 during that time frame and had no knowledge of the studies being ordered or why interventions had not been placed for the left hip fracture until that time. Nurse #2 stated she, Nurse #1, and the night shift supervisor (Nurse #3) all went to Resident #1's room that night after receiving the phone call from the NP and stated Resident #1 complained of back and hip pain at the time. Nurse #2 did not recall if she performed any physical assessment for Resident #1 other than asked him about his pain. Nurse #2 stated she completed some needed documentation and called EMS to transfer Resident #1 to the ER for evaluation immediately.

An interview with Nurse #3 on 12/30/22 at 9:59 AM revealed she was the supervisor on duty on the evening of 11/27/22 when Nurse #1 and Nurse #2 gained knowledge of radiological studies for Resident #1 which included a left hip fracture. Nurse #3 indicated she had worked several days in during the time frame of 11/22/22 through 11/27/22 and had no knowledge Resident #1 had x-rays ordered, obtained, nor resulted in a hip fracture. Nurse #3 stated she did not provide direct care for Resident #1 and could not address pain management during that time; however, stated she could recall he reported pain to Nurse #1 and Nurse #2 on the evening shift of 11/27/22

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 01/04/2023

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 684	Continued From page 29	F 684		

to early am on 11/28/22 when he was transferred to the ER for evaluation. Nurse #3 indicated she was normally provided a generalized report on all resident conditions for the building during a brief shift to shift report which would include when radiological studies had been ordered and the results; however, she could not recall having any knowledge the studies had been ordered or she would have been on the lookout for the report to be on the fax machine. Nurse #3 stated when results are received from the x-ray company, all abnormalities are to be immediately called the provider, the copies placed in the provider's binder located at the nurses' station and the on-coming nurses to receive report of any pending x-ray results.

An interview with Nurse #4 on 12/30/22 at 12:15 PM revealed she was one of the day shift supervisors/Unit Manager in the facility and was the one who obtained the orders for Resident #1 to have radiological studies of the left hip and spine on 11/22/22 and called the local x-ray company to setup the appointment to have them completed. Nurse #4 indicated when she received orders, her normal process was to inform the nurse assigned to the unit of the resident's orders or changes in condition; however, she could not recall who she informed on 11/22/22 of the orders for the radiological studies or the concerns with changes in therapy and she did not perform a physical assessment of Resident #1 at the time, but strictly requested the x-ray as a recommendation of therapy staff. Nurse #4 further stated after studies are completed, the results are faxed to the facility, and they typically receive a phone call alerting them of abnormal results; however, she could not recall why results were not available for Resident

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 01/04/2023

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 684	Continued From page 30	F 684		

#1's studies during the typical range of 24 hours after the x-ray was obtained. She stated she had not contacted the x-ray company herself to verify the result following the order being made on 11/22/22.

An interview with Nurse #5 on 12/30/22 at 12:00 PM revealed she had worked with Resident #1 during his stay; however, could not verify which dates. Nurse #5 indicated she recalled being notified by a member of therapy that he had complained of pain during his treatment and had some slight swelling in his lower extremity. Nurse #5 stated therapy had placed him back in bed and offloaded his LE's and she asked the Unit Manager about the x-ray results since she was unable to locate them in his medical record. According to Nurse #5, she was told by the Unit Manager that the results were still pending, and she thought she gave him pain medication but stated if it was not listed on the MAR she may have been waiting for an order for additional medication at the time if none was ordered. Nurse #5 explained she was unaware of any falls or injuries which would have resulted in the acute changes to Resident #1 and verified Resident #1 could not have been able to mobilize himself without staff assistance had he fallen.

A telephone interview with Nurse #6 on 12/30/22 at 12:45 PM revealed she was familiar of Resident #1; however, she could not recall the x-ray being ordered stating in spite being on duty when the x-ray was obtained, she had no knowledge of what time it was obtained and at no time looked for a result or performed a physical exam of Resident #1 secondary to his pain or potential for LE shortening.

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 01/04/2023

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 684	Continued From page 31	F 684		

Attempts to interview PTA #2 were unsuccessful.

Attempts to interview Nurse #7 were unsuccessful.

An interview with the Director of Nursing (DON) on 1/4/22 at 10:30 AM revealed she had become aware of Resident #1's x-ray which resulted in a left hip fracture when she arrived to the facility on 11/28/22 and was notified he had been admitted to the hospital. The DON stated she called the x-ray company and began formulating a plan for correcting concerns with notification of results following radiological studies. She further indicated the facility did not hold their normal meeting of the interdisciplinary team on 11/24/22 or 11/25/22 and therefore she was not made aware the results were not obtained on 11/23/22 following the x-ray being performed. The DON indicated she was unaware of any fall or injury that occurred in the facility which would have resulted in the fracture and believed it occurred prior to admission and was undetected during his previous hospital stay. The DON further explained typically all x-ray reports have been obtained within 24 hours following the x-ray being performed but could not explain why staff had not contacted the imaging company when the results continued to be pending after 24 hours nor why no formal assessment of the ongoing complaints of pain or potential LE shortening had been performed as these would be expected to be included in the medical record with any acute change in condition.

The Administrator was notified of immediate jeopardy via telephone on 12/30/22 at 5:20 PM.

F684

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 01/04/2023

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 684	Continued From page 32	F 684		

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

*On 11/22/22 until 11/28/22 the facility failed to provide a comprehensive assessment and note a significant change in condition in resident delaying the medical intervention and treatment including pain interventions to resident #1.

* On 11/22/22 resident #1 had swelling and redness of LLE. In addition, there was pain and shortening of the leg of Resident #1 noted during therapy that was reported to nursing staff and the NP that was not addressed by assessing the resident on 11/22/22 when X Ray was ordered. An X-Ray was ordered on 11/22/22 with results sent electronically on 11/23/22. X Ray provider failed to fax due to having incorrect fax number and made one attempt to call but did not get an answer at the facility and did not make any additional attempts. Facility failed to access results until 11/28/22 at which time it was discovered to be a displaced subcapital fracture neck femur and resident was sent to ED.

*All other residents with X Ray services were noted at risk for this deficient practice, which was identified, and a self-imposed plan of correction related to the monitoring and completion of x-rays was initiated on 11/28/2022 and completed on 11/30/2022. The facility retains compliance as it relates to the monitoring of x-rays.

*All residents were assessed for undocumented, unreported or unknown changes in condition that would result in a change in the resident plan of care including physician notification, thorough

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 01/04/2023

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 684	Continued From page 33	F 684		

assessment and medical intervention by Unit Managers or designee on 12/30/22 - 12/31/22. No other residents were identified.

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

On 11/28/22 an audit of all X Rays ordered in the last 14 days was completed. No concerns were found.

On 11/28/22 education was provided to all Nurses on reporting of all ordered X Ray results immediately to DON or designee.

On 11/28/22 DON requested a POC from the X Ray provider in relation to no verbal notification of acute X Ray findings as well as correction of fax number and creation of a pop-up screen with DON contact information when no answer at the facility to assure notification.

On 11/28/22 and ongoing all X Rays will be reported to the DON or Designee when ordered and will be followed up daily until results are received. X Rays will be listed and monitored on a whiteboard each morning during morning meeting as well as the Nurse Manager office and documented on Audit form until the results are received.

The DON was educated on 11/28/22 by the Regional Clinical Director. Education provided was specifically related to change of condition (specifically related to pain) and the new process of tracking pending diagnostics tracking log to

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 01/04/2023

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 684	Continued From page 34	F 684		

ensure compliance and effectiveness. The ADON and Unit Managers were educated by the DON on 11/28/22. Education provided was specifically related to change of condition (specifically related to pain) and the new process of tracking pending diagnostics tracking log to ensure compliance and effectiveness.

On 12/30/22 - 12/31/22 all direct care staff were educated to include Therapy staff by the DON, ADON, Unit Managers or designee to immediately report changes in condition (specifically related to pain, including change in appearance of the human anatomy) including a change in behavior, ADL, or participation in activities, therapy or other usual patterns to licensed nurses. This education including verbal indications as well as non-verbal indications including grimacing, withdrawing, mental status changes, etc for those residents who may not be able to verbalize a change in condition including but not limited to increased pain. NP was educated on the expectation and importance of completing assessment when notified of change in condition and/or pain.

All licensed nurses working and the Nurse Practitioner were educated on thorough assessment related to change in condition and/or pain; and reporting to Physician or Physician Extender (Nurse Practitioner) immediately on 12/30/22 - 12/31/22 by DON, ADON, Unit Manager or designee. All other licensed staff members who were not present, including agency staff will receive training to include the above information prior to returning to work. The director of nursing and administrator will be responsible to ensure this occurs.

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 01/04/2023

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 684	Continued From page 35 Alleged IJ removal date is 1/1/23. The credible allegation was removed on 1/1/23 with a validation completed on 1/4/23 through staff interview and in-service training records. Staff were able to verbalize the process of the facility for ordering x-rays, tracking and obtaining radiological study results, and follow-up with the provider with results immediately. Staff were able to demonstrate the process established through the electronic medical record and vocalize all abnormal results were now called to the DON by the mobile x-ray company as well as fax the report and call the facility with abnormal results. Additionally, staff were able to vocalize understanding of the requirements for a physical assessment to recognize acute changes in condition of a resident as well as the urgency to obtain medical interventions for significant changes in condition.	F 684		