DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u> </u>	B NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		NSTRUCTION		DATE SURVEY COMPLETED
		345080	B. WING				C 11/17/2022
NAME OF PF	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		11/11/2022
	ENS AT VIEWMONT			220 1	3TH AVENUE PLACE NW		
				HICK	(ORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000	survey was conducte 11/9/22. The facility v		F 01	00			
	investigation was con 11/9/22 with additiona through 11/17/22. The compliance was valid Therefore, the exit da 1 of the 4 complaint a resulting in deficienci were investigated NC	e credible allegation of ated on 11/17/22. Ite was changed to 11/17/22. Illegations was substantiated es. The following intakes 00194150 and #NC00194150 resulted in					
	Immediate Jeopardy	was identified at:					
	(J)	600 at a scope and severity 610 at a scope and severity					
	The tags F600 and F Quality of Care.	610 constituted Substandard					
F 000	removed on 11/10/22 conducted on 11/17/2 was validated on 11/1						40/0/22
F 600 SS=J	Free from Abuse and CFR(s): 483.12(a)(1)	Neglect	F 6	00			12/9/22
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE
	cally Signed		-				12/07/2022

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

	MENT OF HEALTH AN S FOR MEDICARE & N	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/13/2022 1 APPROVED): 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		LETED
		345080	B. WING _			(11/	C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT VIEWMONT			ŀ	HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Exploitation The resident has the r neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chemi treat the resident's me §483.12(a) The facility §483.12(a)(1) Not use physical abuse, corpo involuntary seclusion; This REQUIREMENT by: Based on record revie interviews, the facility right to be free from p abuse for one of two r abuse occurred on 8/7 shift (3-11 PM). Nurse she was standing in th resident's room (Reside observed NA #1 grab while attempting to tra- chair to a bedside cor- was resistive to a bath Resident #336 the rig resulted in a skin tear and according to inter and Staff (NA #2, NA # Resident #336 to be five mant her to care for her The immediate jeopar	n Abuse, Neglect, and right to be free from abuse, tion of resident property, fined in this subpart. This ited to freedom from involuntary seclusion and cal restraint not required to edical symptoms. / must- everbal, mental, sexual, or ral punishment, or is not met as evidenced ews, family and staff failed to protect a resident's hysical and/or emotional residents sampled. The 19/22 during the evening e aide #4 (NA #4) reported he hallway outside of a dent #336) when she Resident #336's right arm onsfer her from her recliner nmode while Resident #336 h. NA #1 did not allow ht to refuse care which to Resident #336 right arm views of a Family Member #3, and NA #4) caused earful of NA #1 and not	F	600	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusion set forth on the survey report. Our Plan Correction is prepared and executed as means to continuously improve the quat 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 skin tear to a resident's arm. On 8/19/22 the resident was immediate assessed by the Assistant Director of Nursing (ADON) and the skin tear was cleaned and bandaged. On 8/22/22 the Director of Nursing (DC	ns n of s a ality / a	

Facility ID: 923004

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				PRINTED: 12/13/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	B. WING		C 11/17/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1
THE GREENS AT VIEWMONT			220 13TH AVENUE PLACE NW HICKORY, NC 28601	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
Resident #336 being cared for by NA #1. T removed on 11/10/22 implemented a credit jeopardy removal. Th compliance at lower s actual harm that is im monitoring systems th effective.Findings included:1. Resident #336 was 7/16/22 with a diagno #336 expired on 9/10A quarterly Minimum 7/20/22 indicated Resi intact and required ex mobility, toileting, and indicated Resident #3 behaviors, had no me received no psychotryA telephone interview Nurse Aide (NA) #4 v revealed she witness the doorway of Resid shift of 8/19/22. NA # shift began, she was Resident #336 told N shower. NA #4 stated the doorway because the NA assigned to p	kin tear to the right arm and extremely fearful of being The immediate jeopardy was when the facility ole allegation of immediate e facility will remain out of scope and severity "D" (no immediate jeopardy) to ensure that were put into place are s readmitted to the facility on basis of heart failure. Resident /22 under Hospice services. Data Set (MDS) dated sident #336 was cognitively ktensive assistance for bed d transfers. It further 336 had exhibited no ental health diagnosis, and	F 600		asures hoved event

Facility ID: 923004

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	(X3) DATE SU	938-03
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	COMPLET	
					с	
		345080	B. WING		11/17/	2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP		
				220 13TH AVENUE PLACE NW		
THE GRE	ENS AT VIEWMONT			HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE CONTRACTION SHOULD BE CONTRACTION SHOULD BE CONTRACTION OF THE APPROPRIATE CONTRACTION OF THE APPROPRIATE CONTRACTION SHOULD BE CONTRACTION SHOULD SH	(X5) OMPLETIC DATE
F 600	Continued From page	e 3	F 60	00		
		arm and transfer her roughly		related to these infraction	ns. If	
	in a jerking motion fro			Administrator or Director		
		IA #4 stated she immediately		(DON) are not present in	-	
	entered the room and	d questioned NA #4 why she		supervisors must be notif	fied, and they	
	•	t #336 in that way and NA #4		must inform the Administ		
		an't do that". NA #4 indicated		of Nursing (DON) immed		
		t prove it; I'll say she did it		or by phone. Signs and s		
		e commode because she		abuse and mental anguis		
	hurts herself often".	oom and went to find a		interest, change in routin alterations, or difficulty ea		
	-	ed she thought the nurse was		does not condone and ha		
		ot verify the nurses' identity		for resident abuse by any		
		ed there were 2 to 3 nurses		staff members, physician		
	outside of the room w	when she exited, and she told		volunteers, staff of other		
	an agency nurse who	was outside the room at the		the resident, family mem	bers, legal	
		tnessed between NA #1 and		guardians, sponsors, oth		
		4 stated later that night,		friends, or other individua		
		ssed to her that she was		education focused on tac		
		felt like she handled her to		difficult residents such as		
		isten when she said she did		allow for de-escalation, p		
	-	ovide bathing care. NA #4 note under the door of the		time/place orientation, us tone of voice, providing g	c	
		sing) later in the shift or on		cueing, use of gestures,		
		nake her aware of what		distractions such as activ		
	•••	eported to her because NA		person-centered strategi		
		from the care of Resident		personal memorabilia).		
		cident and Resident #336				
		afraid of NA #1 and did not		This training will be provi		
	want NA #1 to care for	or her anymore.		Administrator or the Hum		
		44/0/00 + 44 07		Director to all agency sta		
	-	/ on 11/9/22 at 11:07AM with		employees upon hire dur	•	
		d. NA #1 revealed she was Resident #336 on 8/19/22		All facility staff in all depa including as needed and		
		nift. NA #1 indicated she had		received this training on		
		B6's room to take her for her		and all staff will continue		
		he shift began. NA #1 stated		training yearly thereafter.		
	-	ront of Resident #336 when		Administrator and Humar		
	-	er call light or recliner chair		Director were notified by		

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	OMPLETED
			A. BUILDING			С
		345080	B. WING			
		343000		STREET ADDRESS, CITY, STATE, ZIP CO		11/17/2022
NAME OF P	ROVIDER OR SUPPLIER				JDE	
THE GRE	ENS AT VIEWMONT			220 13TH AVENUE PLACE NW		
	1			HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 600	Continued From page	e 4	F 60	o		
		ain it and when she brought		provide this training to new	hires on	
	her arm up, she had			11/9/22.		
		d transfer Resident #336 to				
		e in order to transfer her		The Director of Nursing/Des	signee will	
	further to the wheelch	nair for her shower, but		conduct weekly audits for (1		
	Resident #336 contin	ued to refuse a shower so		for abuse weekly for (4) wee	eks, and (5)	
	she left the room to m	nake a nurse aware		residents for abuse weekly	for (4) weeks,	
	Resident #336 had su	ustained a skin tear that		and (3) residents weekly for	(4) weeks.	
	needed to be assess	ed. She indicated no one				
	was in the room with	her when the incident		The Director of Nursing / De	-	
		cknowledged NA #4 entered		report the results of the aud		
	-	the incident occurred		facility's monthly Quality As		
	-	ppened to Resident #336's		Process Improvement (QAF		
		t elaborate on what was		for (3) months and audits w		
		er and NA #4 other than NA		the discretion of the QAPI c	ommittee.	
		tear had occurred. NA #1				
		kly left the room and NA #1		The Director of Nursing is re		
		on the cart about the skin		implementing the corrective	action.	
		ne nurse she told was an				
		ed to be either Nurse # 4 or		The facility will be in full con	•	
		uld not be certain which she		this Plan of Correction no la	ter than	
		ere was either 2 to 3 nurses		12/9/2022		
		cart at the time. NA #1				
		ad made accusations that				
		injury which made her feel				
		aring for Resident #336				
		cated she told a nurse who				
		(unable to identify the nurse)				
		the skin tear occurred, she				
	-	d Unit Manager about				
		Resident #336 was a 2				
	-	fer both for her safety and				
		#1 stated she continued to				
	-	dent #336 periodically until				
		approximately 3 weeks after				
		she felt that Resident #336				
	had confused her and	d another NA who formerly				
		that fit a very similar				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/13/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345080	B. WING			_		C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				22	20 13TH AVENUE PLACE	NW		
THE GREE	ENS AT VIEWMONT			н	ICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	worked with Resident incident occurred. An offsite face to face 11/10/22 at 11:00 AM at her request. NA #1 the team and revealed sustain the skin tear to	I appearance and had #336 shortly before the follow-up interview on with NA #1 was conducted met with 2 surveyors from d Resident #336 did not o her right arm by grabbing	F	600				
	for a reacher (a device up) nor on a bedside of skin tear occurred as table/cabinet which we recliner chair before s acknowledged she hat for a shower but Reside assistance. NA #1 det her and NA #4 but act the room shortly after asking Resident #3360 NA #4 left the room at she went following be room. NA #1 also stat NA #4 and NA #3 had may not want to care due to the allegation. notification happened 8/19/22 or over the we through 8/21/22) but we had alleged that "a NA NA #1 stated she felt had confused her ider mixed up with NA #12	e used assist to pick items commode. NA #1 stated the a result of a white bedside as near the residents' he was transferred. NA #1 d transferred Resident #336 dent #336 refused bathing nied the interaction between knowledged NA #4 entered the incident occurred what had happen and that nd NA #1 was unsure where ing in Resident #336's ed when she came on shift, mentioned to her that she for Resident #336 alone NA #1 was uncertain if this on the start of the shift on eekend following (8/20/22 was aware Resident #336 A" had caused the skin tear. as though Resident #336 ntification and had her NA #1 stated she twas an agency nurse she however, NA #1 was						
	between her and the facility	facility on 11/8/22 that it was to be the ADON (Assistant NA #1 further indicated						

Facility ID: 923004

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345080	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 220 13TH AVENUE PLACE NW	<u> </u>	
THE GRE	ENS AT VIEWMONT				HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 600	nurse when the nurse her, "Look what you of she meant because the belongings in her root incident. An interview with the PM revealed she was assigned to care for F during the evening she recalled being outside incident occurred and room when she heard The ADON stated she allegation; however, w NA #1 standing in from she entered the room ADON verified when a #336's skin on the even an area approximatel was described as pust type fashion with mini- could not recall seein The ADON said Reside arm when she grabble ADON could not veriff #336 had said. A follow-up interview 11:58 AM revealed she not completed a note record on 8/19/22 with incident that occurred The ADON stated she come to her on 8/23/2 complete a note in the recall from the incider	to both NA #1 and the e entered the room to assess did to me" but she thought hey had to rearrange her m and not because of the ADON on 11/8/22 at 5:18 the nurse who was Resident #336 on 8/19/22 dift. The ADON stated she e in the hallway when the went in Resident #336's d the resident holler "Ow". e did not witness the alleged was able to confirm she saw nt of Resident #336 when to assess the resident. The she assessed Resident ening of 8/19/22, there was y 1.5" by 1" where the skin she backwards in a flap imal bleeding visible, but she g visible bruising at the time. dent #336 said she hurt her ed for a reacher, but the y exactly what Resident with the ADON on 11/9/22 at he was unsure why she had in Resident #336's medical h details surrounding the I that resulted in a skin tear. e thought the DON had	F	600			

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M					FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345080	B. WING				C 17/2022
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREENS AT VIEWMONT				20 13TH AVENUE PLACE NW IICKORY, NC 28601		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
or NAs were near the about the skin tear by saw NA #1 standing ir when she entered the explained she did not a statement of what or incident but usually we that occur. A Situation Backgrour Recommendation (SE ADON dated 8/19/22) had a change in skin of as a skin tear at approx A progress note writte 8/23/22 at 4:03 PM re 8/23/22 at 3:55 PM: "1 #336 out of her room 7 Resident #336 dropped attempted to pick it up the bedside commode had a skin tear and sh dressing applied. The to wait until after she f would apply a dressin Wound Nurse and ask to Resident #336's arr told her to use Xerofor the right arm. The ADD Resident #336's beds set away from the resi dropped any object th arm on the side of the	ot recall if any other nurses room when she was told NA #1 but did recall she of front of Resident #336 room. The ADON think to ask NA #1 to write ccurred following the build do that for all incidents ould do that for all incidents the ASSESSMENT BAR) form completed by the indicated Resident #336 color or condition identified oximately 4:30 PM. In by the ADON dated ad in part: Late entry for NA #1 brought Resident to take a shower and stated ed her call light and o and scratched her arm on e. Resident #336's right arm ne wanted to have a ADON told Resident #336 had a bath, then the ADON g. The ADON went to the ked what dressing to apply m and the Wound Nurse am and a dry dressing to ON informed NA #1 that ide commode needed to be ident's side so if she en her arm would not hit her	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345080	B. WING			1	C / 17/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	220 13TH AVENUE PLACE NW		
THE GREI	ENS AT VIEWMONT			ŀ	HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 600	Continued From page	98	F	600)		
	Attempts were made success.	to contact Nurse #5 without					
	NA #3 was conducted learned of an incident she worked on the ev stated she went in to noticed the bandage directly below the bar to go to the hospital of #3 stated Resident # been grabbed by the before which resulted bruise to the right arm report by Resident #3 was working the med the nurses' name) an #336 had said. NA #3 her she was aware of had been made awar Resident #336 had had commode. NA #3 state	on 11/8/22 at 11:47 AM with d. NA #3 revealed she t with Resident #336 when rening shift of 8/20/22. NA #3 see Resident #336 and on her arm and bruising hdage and asked if she had or if she had hurt herself. NA 336 reported to her she had arm by NA #1 on the day in a skin tear and a dark h. NA #3 stated following the 36, she went to a nurse who ication cart (unable to recall d told her what Resident 8 stated that the nurse told if the report and the DON e and seemed to think urt her arm on the bedside ted since she made the ught she would handle it					
	NA #2 was conducted she learned of an inci- when she worked ever stated Resident #336 been yanked up by th before which caused to the right arm. NA # by Resident #336 alo arm and bruising dire told her nurse on the	on 11/8/22 at 9:40 AM with d. Nurse Aide #2 revealed ident with Resident #336 ening shift on 8/20/22. NA #2 reported to her she had he arm by NA #1 on the day some skin tears and bruises t2 stated following the report ing with the bandage on her ctly below the bandage, she unit (unable to recall nurses hey thought the injury had					

Facility ID: 923004

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		MEDICAID SERVICES				O. 0938-039		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY		
			A. BUILDING	3				
		245000				С		
		345080	B. WING			11/17/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	DE			
THE GREE	ENS AT VIEWMONT			220 13TH AVENUE PLACE NW HICKORY, NC 28601				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
F 600	Continued From page	e 9	F 60	00				
		side commode on 8/19/22.						
		o notified the DON at the						
		stated to the DON, "I'd						
		and know the residents were						
	taken care of than to	have them mistreated by						
	another staff membe	r".						
		v on 11/8/22 at 4:32 PM with						
		conducted. The family						
		ral months ago while she						
		Friday night (8/19/22), she						
		I from the facility alerting her ad sustained a skin tear to						
		nity from her bedside						
		y member stated initially she						
		with the incident because she						
		#336 head sustained skin						
	tears in the past. The	e family member explained						
	she did not become of	concerned until she spoke to						
		none over the weekend. The						
	family member stated	a .						
		e resident, Resident #336						
		id caused the skin tear						
		r Resident #336 had told NA						
	told her that it would	a shower and that NA #1 had						
		d and staff would believe NA						
		The family member stated						
		own late on Monday evening						
		ay (8/23), while she was						
		ember received a phone call						
		stating Resident #336						
	-	ember to come to the facility						
	-	she was extremely fearful						
		y member recalled she was						
		ned to Resident #336's room						
	to provide bathing as (8/23) and Resident #	sistance again on that day						

Facility ID: 923004

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 12/13/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>				(X3) DATE COMP	SURVEY LETED
		345080	B. WING			_		C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				2	20 13TH AVENUE PLACE	NW		
THE GREE	ENS AT VIEWMONT			н	ICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	one." The family mem the facility and request that she wished to spe family member stated request, she received DON. During the phot said she told the DON to come to Resident #3 questioned the DON at #336 had sustained at told by the DON that I sustained it on the be Resident #336 stated family member and th her and caused the sl in the room again to m provide bathing and th Resident #336 pointer the one that caused the the room immediately the DON insinuated d Resident #336 was ly her allegation and sai happened, remember bedside commode" at subject to start discuss Resident #336 instead vocalized Resident #3 #1 for the remainder of weeks) and begged th leave town again. Th one should not have b	ted a bath, I am giving you ber indicated she rushed to the staff to alert the DON eak to her urgently. The a few minutes after the a telephone call from the ne call, the family member I she was in the facility and 336's room, which she did. sported when the DON 336's room on 8/23/22, she about the skin tear Resident nd how it occurred and was Resident #336 had dside commode on 8/19/22. in the presence of the e DON that NA #1 had hurt kin tear. NA #1 had arrived nake additional attempts to ne family member explained d to NA #1 and stated she is ne skin tear and NA #1 left . The family member stated uring this conversation ing when she talked over d "no, that is not what , you got that on the nd quickly changed the sing how to transfer	F	600				
	An interview with the	Wound Nurse on 11/9/22 at						

Facility ID: 923004

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		345080	B. WING				C / 17/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
					220 13TH AVENUE PLACE NW		
THE GRE					HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	 9:30 AM revealed she Resident #336's arm ADON on 8/23/22 to of treatment. The Wound aware of the incident or she would have as note, and obtained ar the medical record. T Resident #336 had su past and therefore at could not recall exact Resident #336's right saw it on 8/23/22, but wrote the order for tree medical record on that An interview with the 11/8/22 at 10:57 AM v indicated they had no of abuse. The DON re spoke to Resident #33 tear occurred; howeve conversation surround NA #1. A follow-up interview 5:03 PM revealed she Resident #336 and in always sat in a recline bed. She also indicate previously been able independently from th commode with the us after her most recent additional assistance explained Resident #3 and able to make her DON stated the family 	e learned of the skin tear to when she was asked by the obtain an order for d Nurse stated she was not on 8/19/22 when it occurred sessed the area, made a nd wrote a treatment order in he Wound Nurse stated ustained skin tears in the the time of the interview ly what the skin tear to arm looked like when she verified she obtained and eatment in Resident #336's it date. DON and Administrator on was conducted. They both knowledge of the allegation ecalled she had previously 36's family when the skin er, did not recall any ding the allegation against with the DON on 11/8/22 at e was very familiar with dicated Resident #336 er and refused to lay in a ed Resident #336 had to transfer herself he recliner to the bedside e of her walker; however, admission, she required	F	600			

Facility ID: 923004

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED	
		345080	B. WING				C / 17/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	ENS AT VIEWMONT				220 13TH AVENUE PLACE NW		
					HICKORY, NC 28601		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERE		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	VE ACTION SHOULD BE CC ED TO THE APPROPRIATE			
F 600	tear) occurred and Re that she had not been tear but did not name she reminded Reside occurred from her bee of the need for safer to continued discussing Resident #336's skin techniques. The DON was completed and n obtained at the time of facility felt this incident that didn't look suspic was not present and y the alleged abuse. An additional follow-u 11/9/22 at 12:25 PM s knowledge of the alleg entered the facility on she had been educated interdisciplinary team next day during clinica cause had been ident SBAR and incident re obtained and entered The Administrator, Din corporate consultant y jeopardy on 11/9/22 at The facility provided to allegation for IJ removies o Identify those recipi	two after the incident (skin esident #336 had told her in the one to cause the skin anyone that caused it, but int #336 that the incident dside commode as a result ransfer techniques and interventions to protect and safe transfer I verified no incident report in witness statements were of the incident because the it to be an ordinary skin tear ious. The DON stated she verified she did not witness p interview with the DON on stated she had no gation until the survey team 11/7/22. The DON indicated ed, with all incidents, the should review them on the al meeting to ensure a root iffied, a nurses note, a port completed, and orders the EMR. rector of Nursing, and a were notified of immediate it 5:30 PM. the following credible val: ents who have suffered, or serious adverse outcome as	F	600			

Facility ID: 923004

If continuation sheet Page 13 of 42

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345080	B. WING				C /17/2022
NAME OF PI	ROVIDER OR SUPPLIER	I	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREI	ENS AT VIEWMONT				220 13TH AVENUE PLACE NW HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	* On 8/19/22 resident and mental anguish a *All other residents and the deficient practice resistive to care were abuse. On 11/9/22, an audit of Interview of Mental St was completed by the Managers or designe experienced any type concerns were found. On 11/8/22, an audit assessment of all res less was completed by determine if there is e concerns were found. o Specify the action th process or system fai adverse outcome from when the action will b On 11/8/22, education Administrator, DON, a RN by the Corporate Director of Operations abuse as defined in th resident's right to be failed.	ity failed to protect a free from physical abuse. ##336 sustained a skin tear as a result of physical abuse. The at risk from suffering from and resident who are identified as more at risk for of all residents with a Brief tatus (BIMS) of 10 or above, a DON, ADON, and Unit e to determine if they have a of resident abuse. No consisting of thorough skin idents with a BIMS of 9 or by licensed nurses to evidence of abuse. No the entity will take to alter the lure to prevent a serious in occurring or recurring, and the complete is was provided to the and the Staff Development Consultant, Regional s, regarding the definition of the abuse policy and the free from abuse.	F	60			
	outlined above, educa	after being reeducated as ation for all staff was and via phone by the Staff					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	
		345080	B. WING				- 17/2022
	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE 220 13TH AVENUE PLACE NW HICKORY, NC 28601	<u> </u>	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE			
F 600	Development RN. The the following: " The definition of primediately notify the issues related to thes Administrator or DON supervisors must be minform the Administrator person or by phone " Signs and sympt anguish such as loss routine, mood alterati " Our facility does tolerance for resident staff members, physic volunteers, staff of oth resident, family men sponsors, other reside individuals. " the education for difficult residents such for de-escalation, pro using a soothing tone tactile cueing, use of distractions such active person-centered stratt memorabilia) This training will be pr or the Human Resour staff and new employ orientation. All facility including as-needed a this training on 11/8/2 continue to receive th The Administrator and were notified by the F	abuse, neglect and roperty and the need to e Administrator or DON of all e infractions. If are not present in facility, notified, and they must tor or DON immediately in oms of abuse and mental of interest, change in ons, or difficulty eating not condone and has zero abuse by anyone, including cians, consultants, ner agencies serving the abers, legal guardians, ents, friends, or other sused on tactics to deal with n as walking away to allow viding time/place orientation, of voice, providing gentle gestures, offering vities, music, or egies (pictures, personal rovided by the Administrator rce Director to all agency ees upon hire during staff in all departments, and agency staff, received 2-11/9/22 and all staff will e training yearly thereafter. d Human Resource Director	F	600			

Facility ID: 923004

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S FOR MEDICARE & I				OMB NO	D. 0938-0391
DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
	345080	B. WING			/17/2022
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ENS AT VIEWMONT			220 13TH AVENUE PLACE NW		
				DECTION	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
15	: 15	F 60	00		
new hires on 11/9/22.					
Alleged IJ removal da	te is 11/10/22.				
with a completion date through staff interview training records. Staff examples of abuse to emotional, financial at to verbalize they were allegations of abuse r Administrator and the include after hours an Investigate/Prevent/C CFR(s): 483.12(c)(2)-	e of 11/10/22 was validated y and review of in-service were able to verbalize include physical, mental, nd sexual. Each were able to report all susupected or egardless of source to the Director of Nursing to d weekends. orrect Alleged Violation (4)	F 6'	10		12/9/22
neglect, exploitation, o must:	or mistreatment, the facility				
	-				
neglect, exploitation, o	or mistreatment while the				
investigations to the a designated represent accordance with State Survey Agency, withir incident, and if the all appropriate corrective This REQUIREMENT by:	administrator or his or her ative and to other officials in a law, including to the State a 5 working days of the eged violation is verified action must be taken. is not met as evidenced		Preparation, submission and		
	ROVIDER OR SUPPLIER ENS AT VIEWMONT SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page new hires on 11/9/22. Alleged IJ removal da On 11/17/22 the credi with a completion date through staff interview training records. Staff examples of abuse to emotional, financial and to verbalize they were allegations of abuse r Administrator and the include after hours and Investigate/Prevent/C CFR(s): 483.12(c)(2)- §483.12(c) In response neglect, exploitation, of must: §483.12(c)(2) Have efficient violations are thoroug §483.12(c)(4) Report investigation is in prose §483.12(c)(4) Report investigations to the and designated representa accordance with State Survey Agency, withir incident, and if the alle appropriate corrective This REQUIREMENT by:	ROVIDER OR SUPPLIER ENS AT VIEWMONT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all 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 Iaw, 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	A BUILDIN BUMMARY STATEMENT OF DEFICIENCIES CONTINUES E PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 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. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) F 6 §483.12(c)(1) 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 investigation is the administrator or his or her designated representative and to other officials in accordance with State Iaw, 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:	A BUILING 345080 STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER SPEAK OF DE PICIL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF COR (REAH DEFICIENCIES ID PROVIDERS PLAN OF COR (REAH DEFICIENCIES ID PROVIDERS PLAN OF COR (REAH CORRECTIVE ACTION) Continued From page 15 F 600 Cont11/1/022 On 11/1/02	A BUILING 11 STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE Continued From Supplication STREET ADDRESS, CITY, STATE, ZIP CODE Continued From Supplication OF DESIGNACIES Image: Stat VIEWMONT PROFINE Continued From page 15 PROFINE new hires on 11/9/22. F600 Continued From page 15 F600 new hires on 11/9/22. F600 On 11/17/22 the credible allegation of LJ 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 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 to include physical, mental, emotional, financial and sexual. Each were able to verbalize they were to report all susupected or cols. Staff were able to verbalize they were to report all susupected or unservice verbalize they were to report all susupected or cols. Staff were able to verbalize they were to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: \$483.12(c)(2) Have evidence that all alleged violation crites are thoroughly investigated. \$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

Event ID: XYR311

Facility ID: 923004

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/13/2 FORM APPRO OMB NO. 0938-0
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345080	B. WING		11/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•
THE GRE	ENS AT VIEWMONT			220 13TH AVENUE PLACE NW HICKORY, NC 28601	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMPLET HE APPROPRIATE DATE
F 610	#1) was allowed to co after an allegation of her and according to Member and Staff (N. caused Resident #33 not want her to care f failed to investigate a by a cognitively intact the allegation to the S Protective Services (/ enforcement for 1 of 3 abuse (Resident #330 The immediate jeopa NA #1 was allowed to residents in the facilit abuse was made aga a skin tear and bruisin arm and according to left Resident #336 feat immediate jeopardy w when the facility impleted the state of	r failed to protect all y when Nurse Aide #1 (NA ontinue to care for residents abuse was made against interviews of a Family A #2, NA #3, and NA #4) 6 to be fearful of NA #1 and for her. The facility also n allegation of abuse made t resident and failed to report State Agency (SA), Adult APS) and local law 2 residents reviewed for 6). rdy began on 8/19/22 when o continue to provide care to y after an allegation of ainst NA #1 which resulted in ng to Resident #336's right o staff and family interviews arful of NA #1. The was removed on 11/10/22	F 61	 implementation of this Plan does not constitute an admi agreement with the facts an set forth on the survey repor Correction is prepared and means to continuously impr of care and to comply with a applicable State and Federa requirements. Corrective a accomplished for the allege practice when the facility fai protect, assess other reside thoroughly investigate an al abuse when Resident recei- during transfer while being care. On 11/9/22 a 24 hour report the Administrator. Law Enfo Adult Protective Services w On 11/9/22 the Administrator Nursing (DON), Assistant D Nursing (ADON), and (2) U immediately began the inve 	ission or ad conclusions irt. Our Plan of executed as a rove the quality all the al regulatory ction was ad deficient iled to identify, ents, and legation of ved a skin tear resistive to t was filed by preement and ere notified. or, Director of nit Managers
	scope and severity "E immediate jeopardy) systems are put into Findings included: 1. Resident #336 was 7/16/22 with a diagno #336 expired on 9/10 A quarterly Minimum 7/20/22 indicated Res			the alleged abuse. The find investigation were that the a unsubstantiated. The Depar Health and Human Services Personnel Registry Section that no further investigation conducted in this case. All residents are at risk from from the deficient practice a who are resistive to care are more at risk for abuse.	abuse was rtment of s/Health Care s Determined will be n suffering and residents

Facility ID: 923004

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			<u> </u>	NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	· · ·	TE SURVEY
					С	
		345080	B. WING			1/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ	
THE GRE	ENS AT VIEWMONT			220 13TH AVENUE PLACE NW HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 610	Continued From page	e 17	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 		FOI	 On 11/9/22, an audit was com interviewing all residents with Interview of Mental Status (BII above by Director of Nursing (Assistant Director of Nursing (Unit Managers or designee to who could alert staff to instance abuse. These residents were for unreported abuse occurrer other residents were identified abused and not reported. On 11/8/22, an audit consistin thorough skin assessment of a with a BIMS of 9 or less was colicensed nurses to determine i evidence that these residents experienced any type of abuse residents were identified as be and not reported. 	a Brief MS) of 10 or DON), ADON), and determine ces of interviewed nces. No I as being g of all residents completed by if there is have e. No other	
	roughly almost jerking the bedside commod immediately entered #4 why she did that a can't do that". NA #4 can't prove it; I'll say s bedside commode be often". NA #4 stated s room and went to find she thought the nurses verify the nurses ' ide there were 2 to 3 nurs she exited, and she to was outside the room she also left a note u	g motion from her recliner to e. NA #4 stated she the room and questioned NA and NA #4 said to NA #1 "you indicated NA #1 said "you she did it herself on the ecause she hurts herself she immediately left the d a nurse. NA #4 indicated e was Nurse #4 but could not entity for sure. NA #4 stated ses outside the room when old an agency nurse who n at the time. NA #4 stated nder the door of the DON the following day because		On 11/9/2022 -11/10/22, all sta departments were interviewed members of the interdisciplina (IDT) that consists of Administ Director of Nursing (DON), As Director of Nursing (ADON), a Managers to determine if any resident may have been affect they had observed and not rep abuse. No concerns identified On 11/9/22, the Assistant Dire Nursing (ADON) was reeduca to respond to situations where abuse may have occurred to it assessing the situation, remove potential perpetrator from the	l by ry team rrator, sistant nd (2) Unit other ted and if ported any ctor of ted on how e potential nclude <i>i</i> ng a	

Facility ID: 923004

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							10.0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		TE SURVEY MPLETED	
			A. DOILDIN	<u> </u>			С	
		345080	B. WING			1	1/17/2022	
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•		
				20 13TH AVENUE PLACE NW				
THE GRE	ENS AT VIEWMONT			н	ICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETIO DATE	
F 610	Continued From pag	e 18	F 6	10				
1 010			FO		Administrator			
	#1 and did not want l	old her she was afraid of NA			Administrator			
	anymore.				On 11/8/22, the Administrator, Directo	r of		
					Nursing (DON), and Staff Developmer			
	A telephone interviev	v on 11/9/22 at 11:07AM with			RN were also reeducated on all			
	NA #1 was conducte	d. She indicated no one was			components of the facility⊡s abuse po	olicy		
	in the room with her	when the incident occurred;			and how to identify abuse by the Regi	onal		
		ged NA #4 entered the room			Director of Operations. Education			
	-	ed asking about what			included the definition of abuse, report	ting		
	happened to Resider				requirements, the need to conduct a			
		kly left the room and NA #1			thorough investigation, and monitoring) for		
		on the cart whom she			psychosocial changes by qualified			
		icy nurse identified to be lurse #5 she could not be			individuals, as well as immediately separating the victim from the alleged			
		tified but stated there was			perpetrator.			
		hear the medication cart at						
	-	lized sometime over the			On 11/9/22, after being reeducated as			
	weekend she heard t	that Resident #336 was			outlined above education for all staff w			
	making accusations	that staff had caused the			completed by the Staff Development F	RN.		
	injury which made he	er feel uncomfortable with			The education consisted of the following	ng:		
		336 alone and NA #1			" The definition of abuse and the ne	eed		
		nurse who was on duty that			to immediately notify the Administrator			
		the initial incident, she			Director of Nursing (DON) of all issues	3		
		nd Unit Manager about			related to these infractions. If			
	feeling it was best if I				Administrator or Director of Nursing			
		nsfer both for her safety and A #1 stated she continued to			(DON) are not present in facility, supervisors must be notified, and they	,		
	•	dent #336 periodically until			must inform the Administrator or Direc			
	-	approximately 3 weeks after			of Nursing (DON) immediately in perso			
		she felt that Resident #336			or by phone			
		d another NA who formerly			" Staff members who observe			
	worked in the facility				situations of abuse should immediately	У		
	description of physic	al appearance and had			intervene to prevent continued potenti	al		
		t #336. NA #1 stated she felt			abuse to residents. The perpetrator			
	-	\$336 was confused in her			should be removed from the situation	and		
		her confused with NA #12.			placed under 1:1 supervision by the			
		ntinued to believe it was an			immediate supervisor or designee unti			
		formed on 8/19/22; however,			they can be removed from premises o restricting visitation for accused	r		
	NA #1 was informed	aurina a telephone	1		restricting visitation for accused		1	

Facility ID: 923004

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/13/202 MAPPROVE O. 0938-039	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONST	TRUCTION	СОМ	E SURVEY PLETED	
		345080	B. WING _			C 11/17/2022		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET	ADDRESS, CITY, STATE, ZIP CODE			
THE GRE	ENS AT VIEWMONT				HAVENUE PLACE NW RY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 610	conversation between 11/8/22 that it was be #1 further indicated F NA #1 and the nurse room to assess her, " but she thought she r rearrange her belong a result of the incider NA #1 on 11/10/22 at tear did not occur as commode but accord white bedside table o Resident #336's recli explained at the time #336 stated to both N the nurse came to the what you did to me" to because they had to her room and not as A verification of emple determined her emple to the incident involvi 8/19/22. An interview with the PM revealed she was assigned to care for F during the evening sh recalled being outside incident occurred and room when she heard The ADON stated she allegation; however, N NA #1 standing in fro she entered the room ADON verified when #336's skin on the even	n her and the facility on elieved to be the ADON. NA Resident #336 stated to both when the nurse came to the 'Look what you did to me" meant because they had to ings in her room and not as nt. A follow-up interview with a result of a bedside ing to NA #1 it was from a or cabinet which was near ner chair. NA #1 also of the incident, Resident IA #1 and the nurse when e room to assess her, "Look but she thought she meant rearrange her belongings in a result of the incident. oyment for NA #12 oyment was terminated prior ng Resident #336 on	F6	india resid abu incic Nurs shou a. whic occu b. occu c. d. alleg e. incic f. (i.e. etc.) g. requ " inve a. form b. to d incic c. alleg e. inve a. shou c. d. alleg e. inve a. shou c. d. alleg e. inve a. shou c. d. alleg e. inve a. shou c. d. alleg e. inve a. shou c. d. alleg e. inve a. shou c. d. alleg e. inve a. shou c. d. alleg e. inve a. shou c. d. alleg e. inve a. shou c. d. alleg e. inve a. form b. to d incic d. alleg e. shou c. shou shou shou shou	Any other information that ma uested by management. The individual conducting the estigation will, as a minimum: Review the completed docur	incident of ident uch irector of ormation (s) to ouse acident (c) (if known es to the committed glect, ay be e mentation cal record o the rting the incident edically ding e the poning and		

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CENTER	S FOR MEDICARE &	ND HUMAN SERVICES				RM APPROVEI	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345080	B. WING _		1'	C 1/17/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
				220 13TH AVENUE PLACE NW			
THE GREE	ENS AT VIEWMONT			HICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 610	Continued From page	e 20	F 6	10			
		shed backwards in a flap		who have had contact with	the resident		
		imal bleeding visible, but she		during the period of the alle			
		g visible bruising at the time.		h. Interview the resident	•		
		dent #336 said she hurt her		family members, and visito	•		
		ed for a reacher (a device		i. Interview other resider			
		n to pick up items), but the		accused employee provide			
	-	fy exactly what Resident		services; and			
	#336 had said.	, ,		j. Review all events lead	ling up to the		
				alleged incident	0 1		
	A follow-up interview	with the ADON on 11/9/22 at		k. Preserve all audio and	l video		
	11:58 AM revealed sh	ne was unsure why she did		recordings of the incident (if applicable)		
	not complete a note i	n Resident #336's medical		" In effort to protect resid			
	record on 8/19/22 wit	h details surrounding the		abuse, education included	identification		
		that resulted in a skin tear.		strategies for signs and syr			
		e thought the DON had		abuse such as physical ab			
	come to her on 8/23/2			withdrawal, loss of appetite	-		
	-	e record of what she could		changes in patterns and ps	sychosocial		
		nt because an accusation		well-being			
		nst a nurse aide. The ADON		" Also, in effort to provid			
	stated she went to the			from abuse, keeping reside			
	provided her an order			their community, supporting			
	-	arm skin tear. The ADON		caregivers by identifying ca	-		
		t think about asking NA #1 to what occurred following the		appear stressed or need a working with difficult reside			
		ould do that for all incidents		situation should also be bro	•		
	-	ed if she assists with any		immediate attention of the	-		
		lents in the facility, she		" The fact that our facilit	• •		
		ations are conducted by the		condone and has zero tole	-		
	DON.			resident abuse by anyone,			
				members, physicians, cons	•		
	A Situation Backgrou	nd Assessment		volunteers, staff of other ag			
		BAR) form completed by the		the resident, family memb	•		
		Nursing (ADON) dated		guardians, sponsors, other	-		
		sident #336 had a change in		friends, or other individuals			
	skin color or conditior	n identified as a skin tear at					
	approximately 4:30 P	M but included no other					
	details surrounding th	ne incident.					
				This training will be provide	•		
	There was not a nurs	es note in the medical		Administrator or the Huma	n Resource		

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			0.00			NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	ATE SURVEY OMPLETED
			A. BUILDING	G		С
		345080	B. WING			11/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		11/1//2022
				220 13TH AVENUE PLACE NW	0002	
THE GRE	ENS AT VIEWMONT			HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 610	Continued From page	- <u>21</u>	F 61	10		
1 010	record dated 8/19/22		FU		ff and now	
		arding the skin tear to		Director to all agency sta employees upon hire dur		
	Resident #336's right	-		All facility staff in all depa	-	
		and of the bruising.		including as-needed and		
	A progress note writte	en by the ADON dated		received this training on		
		ead in part: Late entry for		and all staff will continue		
		NA #1 brought Resident		training yearly thereafter.		
		to take a shower and stated		Administrator and Humar		
	Resident #336 dropp			Director were notified by		
		p and scratched her arm on		Director of Operations of		
		e. Resident #336's right arm		provide this training to ne		
	had a skin tear and s	•		11/9/22.		
		ADON told Resident #336				
		had a bath, then the ADON		The Director of Nursing/E	Designee will	
		ng. The ADON went to the		conduct weekly audits for		
		ked what dressing to apply		members for abuse report		
		m and the Wound Nurse		(4) weeks, and (5) staff n		
		oam" and a dry dressing to		abuse reporting weekly for		
		OON informed NA #1 that		(3) staff members for abu		
	•	side commode needed to be		weekly for (4) weeks to e		
	set away from the res			correction is effective and	•	
		nen her arm would not hit her		compliance with the regu		
	arm on the side of the			requirement.	,	
	A telephone interview	/ on 11/9/22 at 2:56 PM with		The Director of Nursing/E	Designee will	
		e was unable to recall		report the results of the a		
	Resident #336 or the	skin tear.		facility⊡s monthly Quality		
				Process Improvement (Q		
	Attempts were made	to contact Nurse #5 without		for (3) months and audits		
	success.			the discretion of the QAP	l committee.	
	A telephone interview	/ on 11/8/22 at 11:47 AM with		The Director of Nursing is		
		d. NA #3 revealed she		implementing the correct	ive action.	
		t with Resident #336 when				
		ening shift of 8/20/22. NA #3		The facility will be in full of		
		see Resident #336 and		this plan of correction no	later than	
	-	on her arm and asked if she		12/9/2022.		
		ital or if she had hurt herself. ht # 336 reported to her she				
			i			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345080	B. WING				C 17/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT VIEWMONT				220 13TH AVENUE PLACE NW HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 610	day before which resu dark bruise to the righ following the report by to a nurse who was w (unable to recall the m what Resident #336 h nurse told her she wat the DON had been m think Resident #336 h bedside commode, so DON planned to furth reported by Resident she made the nurse a would handle it further A telephone interview NA #2 was conducted she learned of an inci when she worked ever stated Resident #336 been yanked up by th before which caused to the right arm. NA # by Resident #336, she and was told they tho on the bedside comm stated she also notifie was told the DON was everyone that might b incorrectly or the facil take care of her reside to the DON, "I'd rathe them mistreated".	the arm by NA #1 on the ulted in a skin tear and a at arm. NA #3 stated y Resident #336, she went vorking the medication cart purses' name) and told her had said. NA #3 stated that is aware of the report and ade aware and seemed to had hurt her arm on the poshe was not sure if the er investigate the incident #336. NA #3 stated since tware she thought she r. on 11/8/22 at 9:40 AM with d. Nurse aide #2 revealed dent with Resident #336 ening shift on 8/20/22. NA #2 reported to her she had e arm by NA #1 on the day some skin tears and bruises 2 stated following the report e told her nurse on the unit ught the injury had occurred ode on 8/19/22. NA #2 ed the DON at the time and s "unable to terminate	F	610			
		al months ago while she					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345080	B. WING			11	C /17/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		///////////////////////////////////////
					220 13TH AVENUE PLACE NW		
THE GRE	ENS AT VIEWMONT				HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 610	was out of town on a phone call from the fa Resident #336 had su right upper extremity The Family Member si concerned with the in aware Resident #336 in the past. The family become concerned un via phone over the we stated during a teleph #336 had notified her tear during a transfer told NA #1 she did no #1 had told her that it Resident #336's word staff over the resident stated she arrived bar evening from a flight a was working, Family N call from Resident #3 needed Family Member immediately. Family N told NA #1 had return to provide bathing ass and Resident #336 ha her to give her a bath not ask if you wanted one." Family Member facility and requested Family Member wishe Family Member states request, she received DON. During the phot she told the DON she come to Resident #33 Family Member #1 in arrived at Resident #3	Friday night, she received a	F	610			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345080	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
					220 13TH AVENUE PLACE NW		
THE GRE	ENS AT VIEWMONT			I	HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 610	the DON about the sk sustained and how it is the DON that Resider the bedside commode stated in the presence DON that NA #1 had tear. NA #1 had arrive make additional atten Family Member report to NA #1 and stated st the skin tear and NA a immediately. Family M insinuated Resident # talked over her allega what happened remet bedside commode" at subject to start discus Resident #336 instea Resident #336 instea Resident #336 remain remainder of her life (begged Family Member subjected to that type in the last days of the An interview with the 11/8/22 at 10:57 AM w indicated they had no of abuse. The DON re spoke to Resident #3 tear occurred; however conversation surround NA #1. A follow-up interview f 5:03 PM revealed the facility to visit her mon the incident occurred	kin tear Resident #336 had occurred and was told by nt #336 had sustained it on e on 8/19/22. Resident #336 e of Family Member and the hurt her and caused the skin ed in the room again to npts to provide bathing and ted Resident #336 pointed she is the one that caused #1 left the room Member stated the DON f336 was lying when she tition and said "no, that is not mber, you got that on the nd quickly changed the ssing how to transfer d. Family Member stated ned fearful of NA #1 for the fapproximately 3 weeks) and ber not to leave town again. d no one should be a of treatment and live in fear ir life. DON and Administrator on was conducted. They both o knowledge of the allegation ecalled she had previously 36 ' s family when the skin	F	610			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345080	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT VIEWMONT				20 13TH AVENUE PLACE NW IICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	tear, but she reminde incident occurred from a result of the need for and continued discuss Resident #336's skin techniques. The DON was completed and n obtained because the be an ordinary skin te The DON stated she she did not witness th stated she was aware resistive to staff provid schedule where hosp each provided one ba An additional follow-u 11/9/22 at 12:25 PM s knowledge of the aller entered the facility on she had been educate interdisciplinary team next day during clinica cause had been ident SBAR and incident re obtained and entered DON did not recall a of herself, Family Membe 8/23/22 where the ski Family Member indica caring for her family n discussed the skin tea status and provided F to remind her to call for room and thought bot	d Resident #336 that the in her bedside commode as or safer transfer techniques sing interventions to protect and safe transfer I verified no incident report o witness statements were ar that 't look suspicious. was not present and verified the alleged abuse. The DON a Resident #336 had been ding bathing assistance due ding bathing on a rotating ice staff and facility staff th each per week. p interview with the DON on stated she had no gation until the survey team 11/7/22. The DON indicated ed, with all incidents, the should review them on the all meeting to ensure a root tified, a nurses note, a port completed, and orders the medical record. The conversation between ther, and Resident #336 on in tear was discussed or that ated she did not want NA #1 nember, but strictly ar and reviewed transfer Resident #336 with a gait belt or assistance and left the th Family Member #1 and satisfied with the resolution.	F	610			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345080	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT VIEWMONT		220 13TH AVENUE PLACE NW HICKORY, NC 28601				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	provided by the facilit 8/23/22 indicated the On 8/19/22, the scheo #1 and NA #4 were as hall on evening shift. indicated NA #3 was evening shift; howeve work an adjacent hall was assigned to work AM) on 08/19/22. On 8/20/22, the scheo assigned to Resident Nurse #3 was schedu schedule further indic scheduled to provide the evening shift; how but assigned to work On 8/21/22, the scheo assigned to Resident NA #1 was assigned to from 4 PM-11 PM. Th NA #2 was assigned to adjacent hall. On 8/22/22, the scheo assigned to Resident adjacent hall. On 8/22/22, the scheo assigned to Resident and NA #3 was assigned from 11 PM and resident from 11 PM to On 8/23/22, NA #1 ar the care of Resident # Nurse #1 was assigned from 7 AM- 11 PM. According to the Nurs Report dated August initial report for verific	y dated 8/19/22 through following: dule indicated Nurse #1, NA ssigned to Resident #336 The documents further also assigned to work on the er, NA #3 was assigned to . It further detailed NA #4 t the night shift (11PM- 7 dule indicated Nurse #2 was #336 from 7AM-7PM and fled from 7PM-7AM. The fated NA #1 and NA #3 were care to Resident #336 on vever, NA #2 was scheduled on an adjacent hall. dule indicated Nurse #1 was #336 from 7AM-11PM and to Resident #336 ' s care e schedule further indicated to work, however on an dule indicated Nurse #4 was #336 from 7 AM to 3 PM ned to the resident from d NA #4 was assigned to the to 7 AM. ad NA #2 were assigned to #336 from 3 PM to 11 PM. ed to Resident #336 ' s care	F	610			

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE). 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· <i>`</i>				LETED
		345080	B. WING				C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE		11/2022
THE GREE	ENS AT VIEWMONT				220 13TH AVENUE PLACE NW		
		ATEMENT OF DEFICIENCIES		1	HICKORY, NC 28601 PROVIDER'S PLAN OF CORRECTION		(1)(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	× 97	Í -	610			
1 010		ported incidents (FRIs) for		010	5		
	August 2022 through	11/7/22 revealed no reports					
		use involving NA #1 and the State Agency (SA),					
		ices (APS), or local law					
	enforcement.						
		rector of Nursing, and a					
	corporate consultant jeopardy on 11/9/22 a	were notified of immediate					
		1 0.00 F W.					
	The facility provided t allegation of IJ remov	-					
		nts who have suffered, or serious adverse outcome as					
	a result of the noncon	npliance					
	*On 8/19/22, the facili	ity failed to identify, protect,					
	assess other resident						
	.	ion of abuse. The facility forcement and APS when					
		#1 abuse resident #336 and					
	-	tion was aware that the f the aide. The perpetrator					
	continued to be assig	ned to provide care for this					
	resident until the resid	dent's death.					
		isk from suffering from the					
	•	residents who are resistive nore at risk for abuse.					
		r report was made to DHSR. Adult Protective Services					
	were notified. An inve	stigation around this					
	incident is underway. conducted by the Adn	This investigation is being ninistrator.					
	-						
	On 11/9/22, an audit v	was completed by					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345080	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
THE GREENS AT VIEWMONT					220 13TH AVENUE PLACE NW HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	interviewing all reside Mental Status (BIMS) of Nursing (DON), As (ADON), and Unit Ma determine who could abuse. These residen unreported abuse occ residents were identif reported. On 11/8/22, an audit of assessment of all resi- less was completed b- determine if there is e- have experienced any residents were identif reported. On 11/9/2022 -11/10/2 departments were inter- interdisciplinary team Administrator, DON, A to determine if any oth affected and if they have reported any abuse. N ·Specify the action the process or system fai adverse outcome from when the action will b- On 11/9/22, the ADON respond to situations	nts with a Brief Interview of of 10 or above by Director sistant Director of Nursing nagers or designee to alert staff to instances of its were interviewed for currences. No other ied as being abused and not consisting of thorough skin idents with a BIMS of 9 or y licensed nurses to widence that these residents y type of abuse. No other ied as being abused and not 22, all staff in all erviewed by members of the (IDT) that consists of ADON, and Unit Managers her resident may have been ad observed and not No concerns identified.	F	610			

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		345080	B. WING				C / 17/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
					220 13TH AVENUE PLACE NW		
THE GRE	ENS AT VIEWMONT			1	HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	On 11/8/22, the Admin Development RN wer components of the fact to identify abuse by th Operations. Education abuse, reporting requi- conduct a thorough in for psychosocial chan as well as immediated the alleged perpetrato On 11/9/22, after bein above education for a the Staff Developmen consisted of the follow The definition of abus immediately notify the issues related to thes Administrator or DON supervisors must be r inform the Administration person or by phone Staff members who o should immediately in continued potential at perpetrator should be and placed under 1:1 immediate supervisor be removed from prei for accused individual facility Any individual observ abuse or suspecting r immediately report su Administrator or Direct following information The name(s) of the re- abuse or suspected a	nistrator, DON, and Staff e also reeducated on all cility's abuse policy and how he Regional Director of in included the definition of irements, the need to investigation, and monitoring ages by qualified individuals, y separating the victim from or. If reeducated as outlined all staff was completed by it RN. The education wing: e and the need to e Administrator or DON of all e infractions. If are not present in facility, notified, and they must tor or DON immediately in bserve situations of abuse thervene to prevent puse to residents. The removed from the situation supervision by the or designee until they can mises or restricting visitation is not employed by the ing an incident of resident resident abuse must ch incident to the stor of Nursing. The should be reported: resident(s) to which the	F	610			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345080	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
THE GRE	ENS AT VIEWMONT				220 13TH AVENUE PLACE NW HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 610	Where the incident to The name(s) of the per- committing the incider The name(s) of any we The type of abuse that verbal, physical, sexue Any other information management. The individual conduct a minimum: Review the completer Review the completer Review the completer Review the resident's determine events lead Interview the person(s) Interview any witness Interview the resident Interview other resident Interview other resident Interview other resident Interview all events lead incident Preserve all audio an incident (if applicable) In effort to protect resident education included id signs and symptoms abnormality, withdraw general changes in par well-being Also, in effort to provi keeping residents end	ok place erson(s) allegedly nt, if known vitnesses to the incident at was committed (i.e., ial, neglect, etc.) that may be requested by cting the investigation will, as d documentation forms medical record to ding up to the incident s) reporting the incident t to the incident t to the incident c (as medically appropriate) is attending physician as the resident ' s current level gnitive condition ers on all shifts who have resident during the period of 's roommate, family souts to whom the accused are of services; and ding up to the alleged d video recordings of the)	F	610			

If continuation sheet Page 31 of 42

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345080	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					220 13TH AVENUE PLACE NW		
THE GRE	ENS AT VIEWMONT		HICKORY, NC 28601				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 610	caregivers who appea from working with diffi situation should also I attention of the super The fact that our facili has zero tolerance for including staff member volunteers, staff of oth resident, family mem sponsors, other reside individuals. This training will be pr or the Human Resour staff and new employ orientation. All facility including as-needed a this training on 11/8/2 continue to receive th The Administrator and were notified by the R Operations of the nee new hires on 11/9/22. Alleged IJ removal da On 11/17/22 the credit jeopardy with a removial validated through staff in-service training rec- verbalize the definition examples as well as well the Administrator or D with any concerns of potential of abuse. St provide written statem or reports made by a family member to the	ar stressed or need a break icult residents. (This be brought to the immediate visor.) ty does not condone and r resident abuse by anyone, ers, physicians, consultants, her agencies serving the abers, legal guardians, ents, friends, or other rovided by the Administrator ree Director to all agency ees upon hire during staff in all departments, and agency staff, received 2-11/9/22 and all staff will e training yearly thereafter. d Human Resource Director Regional Director of ed to provide this training to the is 11/10/22. ble allegation of immediate val date of 11/10/22 was f interview and review of ords. Staff were able to ns of abuse and provided vocalize they were to contact DON via phone or in person observed or reported aff reported they are to nents of their observations resident, staff member, or	F	610	0		

Facility ID: 923004

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	-	ND HUMAN SERVICES				FOR	D: 12/13/202 M APPROVE D. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345080	B. WING			11	C / 17/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE GRE	ENS AT VIEWMONT				20 13TH AVENUE PLACE NW			
					IICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 610	Continued From page	a 32		610				
1 010	· · · · · ·	d and any staff member		010				
		ist be immediately removed						
	from the facility while	-						
		w abuse allegations must be						
		ed to include collecting						
	written witness stater							
E 600	associated with alleg Bowel/Bladder Incon			690			12/9/22	
F 090 SS=D				090			12/9/22	
	§483.25(e) Incontine	nce.						
		cility must ensure that						
		nent of bladder and bowel on						
		ervices and assistance to unless his or her clinical						
		nes such that continence is						
	not possible to mainta							
	§483.25(e)(2)For a re	esident with urinary						
	incontinence, based							
	· .	ssment, the facility must						
	ensure that-	ters the facility without an						
		not catheterized unless the						
	-	dition demonstrates that						
	catheterization was n	-						
		ters the facility with an						
	-	r subsequently receives one val of the catheter as soon						
		e resident's clinical condition						
		theterization is necessary;						
	and	-						
		incontinent of bladder						
		treatment and services to						
	continence to the ext	infections and to restore ent possible.						
	§483.25(e)(3) For a r	esident with fecal						
-								

Facility ID: 923004

If continuation sheet Page 33 of 42

	-	D HUMAN SERVICES				FORM	1 APPROVED
		MEDICAID SERVICES				<u> </u>	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
-			A. BUILDI	NG _			
		345080	B. WING				
	ROVIDER OR SUPPLIER	0.0000			STREET ADDRESS, CITY, STATE, ZIP CODE	I 11/	17/2022
	CONDER ON SOLT EIER				220 13TH AVENUE PLACE NW		
THE GREE					HICKORY, NC 28601		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		
F 690	Continued From name	22	-	~~~			
F 090	Continued From page			690			
	incontinence, based o						
		ssment, the facility must					
		t who is incontinent of bowel					
	restore as much norm	treatment and services to					
	possible.	la bower function as					
	•	is not met as evidenced					
	by:						
		ns, record reviews and staff			Preparation, submission and		
	interviews, the facility			implementation of this Plan of Correction	on		
	catheter tubing and ca			does not constitute an admission of or			
	the floor for 1 of 1 res	ident (Resident #6)			agreement with the facts and conclusion	ons	
	reviewed for urinary c	atheters.			set forth on the survey report. Our Plan		
					Correction is prepared and executed as		
	The finding included:				means to continuously improve the qua	ality	
					of care and to comply with all the		
	Resident #6 was adm	-			applicable state and federal regulatory		
	bladder.	ses that included neurogenic			requirements.		
					Corrective action was accomplished fo	r	
	Resident #6's care pla	an revised on 03/29/22			the alleged deficient practice when the		
		it had an (indwelling urinary)			facility failed to prevent catheter		
		genic bladder. The goal that			tubing/bag from touching the floor. On		
	the Resident would re	main free from catheter			11/7/22, the catheter was placed on		
		be attained by utilizing			wheelchair by the Nurse assigned to the	e	
		anchoring catheter tubing to			hall.		
		king tubing for kinks every					
		and document signs and			All residents with catheters are at risk		
		discomfort due to catheter. A			from suffering from the deficient practic	æ.	
		ipdated care plan revised on			On 11/7/22 on qualit of all residents wh		
		sident #6 was at risk for (UTI) related to urinary			On 11/7/22 an audit of all residents who have catheters was completed to ensu		
	-	al for the Resident to remain			that catheter tubing and catheter bags		
	free of infection would				not touching the floor. None were found		
		delivery of care, observe for					
	-	of urinary infection and			All staff to include agency staff will be		
	provide urinary cathet				educated by the Director of Nursing		
	. ,				(DON) or Designee on the need to kee	р	
	The quarterly Minimu	m Data Set (MDS)			catheter tubing/bags from touching the		

Event ID: XYR311

Facility ID: 923004

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/13/2022 MAPPROVED O. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345080	B. WING			C 11/17/2022		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE GRE	ENS AT VIEWMONT				20 13TH AVENUE PLACE NW ICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 690	was moderately cogn behaviors of rejection indwelling urinary cat On 11/07/22 at 10:43 made of Resident #6 the hallway. The Resi with the catheter tubin touching the floor. On 11/07/22 at 11:14 was made of Resider in the hallway. The Re- tubing and catheter b floor. An observation was n of Resident #6 sitting hallway with his urina catheter bag touching An interview was con #15 on 11/07/22 at 2: was responsible for R The NA acknowledge catheter tubing and b explained that the Re- the time. The NA india tubing should be anch prevent it from touchin An interview was con 11/07/22 at 2:19 PM v urinary catheter bag a explained that the bag secured so that they of infection control purport	 /01/22 revealed Resident #6 itively impaired, had no of care and had an neter. AM an observation was sitting in his wheelchair in dent had a urinary catheter ng and the catheter bag AM a second observation t #6 sitting in his wheelchair esident's urinary catheter ag was touching on the adde on 11/07/22 at 2:10 PM in his wheelchair in the ry catheter tubing and the floor. ducted with Nurse Aide (NA) 11 PM who confirmed she esident #6 during that shift. d that the Resident's urinary ag were on the floor and sident "messes" with it all cated the catheter bag and hored more securely to ng the floor. ducted with Nurse #10 on who observed Resident #6's and tubing on the floor and g and tubing should be did not touch the floor for 	F	690	floor by 12/1/2022. All new hires to include agency staff will be educated the Director of Nursing (DON) or Designee moving forward on the nee keep catheter tubing/bags from touch the floor during orientation. The Director of Nursing/Designee wil conduct weekly audits for (5) residen with catheters a week times (4) week residents with catheters a week times weeks and (1) resident with a cathete week times (4) weeks to assure cathet tubing and bags and free from touch the floor. The Director of Nursing/Designee wil report the results of the audits in the facility's monthly QAPI meetings for (months and audits will continue at the discretion of the Quality Assurance Process Improvement (QAPI) commi The Director of Nursing is responsible implementing the corrective action. The facility will be in full compliance w this plan of correction no later than 12/9/2022	d to hing I ts s, (3) s (4) er a eter ng I 3) e ttee. e for		

Facility ID: 923004

If continuation sheet Page 35 of 42

	-	ID HUMAN SERVICES MEDICAID SERVICES			FO	RM APPROVED NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345080	B. WING		1	1/17/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GREE	ENS AT VIEWMONT			220 13TH AVENUE PLACE NW HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 690	Resident "played" wit and because of that to closer eye on the tubit they did not touch the An interview was con Nursing (DON) who for Preventionist (IP) on DON explained that F and tubing should be bladder and off the flo infections. The DON of Resident #6 had a had catheter and because more vigilant in makin correctly off the floor. During an interview w 11/09/22 at 2:51 PM F Director of Nursing m with Resident #6's unit tubing being on the flo stated it should not had the staff should have to ensure the cathete appropriately secured Respiratory/Tracheos	f the floor and stated the h his catheter all the time he staff should keep a ng and catheter to ensure floor. ducted with the Director of unctioned as the Infection 11/08/22 at 9:30 AM. The Resident #6's catheter bag positioned below his bor to prevent urinary tract continued to explain that bit of "playing" with his e of that the staff should be ng sure it was positioned	F 6	90		12/9/22
SS=D	The facility must ensu- needs respiratory car care and tracheal suc- care, consistent with practice, the compre-	ry care, including ad tracheal suctioning. are that a resident who e, including tracheostomy stioning, is provided such professional standards of nensive person-centered ats' goals and preferences,				

Facility ID: 923004

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Facility ID: 923004

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES			FORM APPROVE OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345080			· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING		C 11/17/2022			
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	·		
				220 13TH AVENUE PLACE NW			
THE GREE	ENS AT VIEWMONT			HICKORY, NC 28601			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION			
F 695	Continued From page 37		F 695	5			
	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.		F 695	All staff to include agency staff will educated prior to working their next by the Director of Nursing or Design the need to confirm the Oxygen lite minute settings are correct and set Physicians ordered settings by 12/ ⁷ All new hires to include agency stat be educated by the Director of Nursi Designee moving forward on the net confirm the Oxygen liters per minut settings are correct and set to the Physicians ordered settings during orientation. The Director of Nursing/Designee w conduct weekly audits for (5) reside using oxygen weekly for (4) weeks, residents using oxygen weekly for (4) weeks to assure Oxy settings are correct and set per Physicians ordered. The Director of Nursing/Designee w report the results of the audits in the facility's monthly QAPI meetings for months and audits will continue at the facility of the facility week weekly for the facility weeks weekly for the facility weekly weekly weekly for the facility weekly weekly weekly weekly weekly for the facility weekly weekly weekly weekly weekly for the facility weekly weekly weekly weekly weekly facility weekly facility weekly weekly weekly facility weekly weekly weekly facility weekly weekly weekly facility weekly weekly weekly weekly facility weekly weekly weekly weekly weekly weekly facility weekly week	t shift nee on rs per to the 1/2022. ff will sing or eed to re vill ents (3) (4) en rgen		
	on 11/09/22 at 9:03 A the night shift and con his CPAP mask on th or if she removed it a stated she was aware	M. She stated she works uld not recall if resident had le early morning of 11/07/22 t the end of her shift. She le the oxygen rate changed at night with his on CPAP on		The Director of Nursing is responsil implementing the corrective action.	nittee. ble for		
		ducted on 11/09/22 11:45 of Nursing (DON) and		this plan of correction no later than 12/9/2022			

Facility ID: 923004

	-	ID HUMAN SERVICES				FORM	MAPPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION							OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345080				A. BUILDING			PLETED	
							с	
		B. WING			11/	17/2022		
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
	ENS AT VIEWMONT				220 13TH AVENUE PLACE NW			
					HICKORY, NC 28601			
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
IAG					DEFICIENCY)			
F 695	Continued From page	238	F	69	5			
	Administrator. The D							
		en is administered per						
		stated she had discussed						
	this with the provider,	and they are going to						
		the oxygen rate is the same						
	during day and night	to avoid confusion.						
	0 Desident #27 educi							
	2. Resident #37 admi	ses that included acute						
		n hypoxia (absence of						
		blood to sustain bodily						
	functions) and asthma							
	,							
	Review of the quarterly Minimum Data Set dated							
	08/23/22 indicated that Resident #37 was							
		y impaired. The MDS further						
		nt #37 required oxygen and ath with exertion and when						
	lying flat.							
	lying nat.							
	Review of an active p	hysician order for November						
	2022 read, oxygen at	3 liters due to chronic						
	respiratory failure with	n hypoxia.						
		nterview of Resident #37						
		eyes open. He was awake						
		asic questions. He was						
		gen in place via nasal						
	•	concentrator next to his						
	bed. He was in no ac	ute distress and stated he						
		ms breathing. The head of						
	his bed was elevated	approximately 15 degrees.						
	An observation of De	sident #37 was made on						
		Resident #37 was made on						
		sed. He was observed to						
	-	via nasal cannula at 2 liters						
		to his bed. He appeared to						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						D: 12/13/2022 M APPROVED O. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
		345080	B. WING			C 11/17/2022	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		////2022	
				220 13TH AVENUE PLACE NW			
THE GREE	ENS AT VIEWMONT		HICKORY, NC 28601				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
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		F 6	95			
F 867 SS=D	sure what the oxygen 37. During an interview w 01:15 PM, the DON c oxygen order and corr at 3 liters/minute. Sho room and assessed h distress. The DON ch saturation (amount of was 95%. The DON th flow to 3 liters/minute. During an interview w Administrator on 11/0 said it was her expect administered per phys QAPI/QAA Improvem CFR(s): 483.75(g)(2)(§483.75(g)(2) The qui assurance committee (ii) Develop and imple action to correct ident	order was for Resident # ith the DON on 11/07/22 at hecked Resident #37's ifirmed it should be running e went to the Resident's im for any respiratory ecked the resident's oxygen oxygen in the blood) which then adjusted the oxygen ith the DON and 9/22 at 11:45 AM, the DON tations that oxygen was sician order. ent Activities (ii) sessment and assurance. ality assessment and	F 8	167		12/9/22	
	Based on observation interviews the facility's Performance Improve failed to maintain imp	ns, record review and staff s Quality Assurance and ement (QAPI) committee lemented procedures and ons that the committee put		F690 related to Catheter Care implemented into the Quality As and Performance Improvement All cited/identified deficient prac	ssurance Program		

Event ID: XYR311

Facility ID: 923004

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETER 345080 B. WING 11/17/20	JRVEY
345080 B. WING 11/17/20	
	//2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE GREENS AT VIEWMONT 220 13TH AVENUE PLACE NW	
HICKORY, NC 28601	
	(X5) COMPLETION DATE
F 867 Continued From page 40 into place following the recertification survey of 325/21. 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 1117/22. 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. Inservice/Education provided to the Quality Assurance and Performance Improvement Committee by the Regional Clinical Director related to the expectation/receponsibility 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. F 980- Based on observations, record reviews and staff interview, the facility failed to prevent a uninary catheter tubing and catheter bag from touching the floor for 1 of 1 resident (Resident #6) reviewed for urinary catheters. Quality Assurance and Performance Improvement (QAPI) Monitoring Tool developed and implemented to ensure each identified area of deficient practice is reviewed in the monthy Quality Assurance and Performance Improvement Committee Meeting. The QAPI Monitoring Tool will include F600, F610, F600, and F635. The QAPI Monitoring Tool will be completed monthy device for resident indveiling catheters for 3 of 3 resident reviewed for uninary 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 would be reimplemented into the facility's quality assurance program to stop the repeated deficiencies. The Administrator to resure compliance and evaluate effectiveness. The QAPI Monitoring Tool will be completed monthy for a conseacutive twelve (12) mon	

Event ID: XYR311

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION							SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
345080			B. WING			C 11/17/2022		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/17/2022		
THE GREE	ENS AT VIEWMONT				20 13TH AVENUE PLACE NW			
(X4) ID	1			HICKORY, NC 28601 PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			FIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION DATE	
F 867			F	867				

Event ID: XYR311

Facility ID: 923004

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