	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345080	B. WING			/ <b>04/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE	_ <b>-</b>	
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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
F 600 SS=J	conducted on 12/29/2 credible allegation of on 1/4/23. 1 of the 2 substantiated resultin following intakes were and NC00195296. In in immediate jeopardy CFR 483.12 at tag F (J) CFR 483.12 at tag F (J) CFR 483.12 at tag F (J) The tags F600 and F Quality of Care. Immediate Jeopardy removed on 1/1/23. A was conducted. Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom fro Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	<ul> <li>a investigated NC00195052</li> <li>itake #NC00195296 resulted</li> <li>y. Event ID #WQDM11.</li> <li>was identified at:</li> <li>600 at a scope and severity</li> <li>684 at a scope and severity</li> <li>684 constituted Substandard</li> <li>began on 11/22/22 and was</li> <li>A partial extended survey</li> <li>Neglect</li> <li>m Abuse, Neglect, and</li> <li>right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.</li> </ul>	F 600			1/5/23
		SUPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE		(X6) DATE
Electroni	cally Signed					01/23/2023

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.

PRINTED: 01/24/2023

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONS	STRUCTION	· · · ·	TE SURVEY	
		345080	B. WING				C )1/04/2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			·		
THE GREI	ENS AT VIEWMONT				TH AVENUE PLACE NW DRY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 600	Continued From page	e 1	F	600				
	physical abuse, corpor involuntary seclusion. This REQUIREMENT by: Based on record revi practitioner (NP), x-ra and staff interviews, t provide necessary ca resident complained of therapy on 11/22/22 a Physical Therapist wh Resident #1's left low x-ray results reported transverse, displaced femoral neck (a trans associated with major typically required surg sub-capital meaning it thigh bone). No facilit acknowledged the x-r continued to report pa- to therapy daily and c due to the severe pai treatment were initiate Practitioner called the 11/27/22 and reported Resident #1 reported of 9 to 10 (10 being th transferred to the hos hip fracture required s repair. This deficient p residents reviewed fo (Resident #1). The Immediate Jeopa	is not met as evidenced iews and family, nurse ay company representative he facility neglected to re and services after a of left lower pain during and was assessed by the no recommended an x-ray of er extremity and spine. The on 11/23/22 noted an acute, is ub capital fracture of the verse break is usually r force, displaced fracture gical intervention for repair, it occurred in the neck of the y staff followed up on or ray results. Resident #1 ain in his left lower extremity on 11/25/22 refused therapy n. No medical evaluation or ed until the Nurse e facility near midnight on d the x-ray results to staff. left hip pain of 9 on a scale ne worst pain) prior to being spital on 11/28/22 and the left surgical intervention for practice occurred for 1 of 3 r professional standards		And Pre- imp doe agr set Co me of c app req acc pra ass Nu ext cor All oth an are pra On res Ma hav cor res	500 □ Freedom from Abuse, N d Exploitation eparation, submission and olementation of this Plan of Co es not constitute an admission reement with the facts and cor i forth on the survey report. O rrection is prepared and exect eans to continuously improve ti care and to comply with all the plicable state and federal regu quirements. Corrective action complished for the alleged def actice by facility staff not comp sessment and communicating rsing Administration and Phys tender residents experiencing p assessment and pending X-ra e at risk of suffering from the d actice. at 12/30/22 □ 12/31/22, an audi idents was completed by the I magers or designee to determ we experienced any pain or ch ndition without treatment and f idents with pending X-ray resi- ncerns were found.	prrection of or nclusions ur Plan of uted as a he quality alatory was icient leting an to 		

Facility ID: 923004

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	S FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		OATE SURVEY
		345080	B. WING			C 01/04/2023	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GRE	ENS AT VIEWMONT				20 13TH AVENUE PLACE NW		
				Н	ICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 2	E E	600			
		ovided. The immediate		000			
		ed on 1/1/23 when the facility			On 12/30/22, education was provide	d to	
		ble allegation of immediate			the Administrator by the Director of		
	· ·	e facility will remain out of			Operations regarding the definition of	of	
		scope and severity "D" (no			neglect.		
	actual harm that is im						
	complete education a	and to ensure monitoring			On 12/31/22 education was provided	l to	
	systems are put into	place are effective.			the Human Resources Director by th	e	
					Administrator regarding the definition		
	Findings included:				neglect and including education to al	ll new	
					hires/agency direct care staff during		
		nitted to the facility on			orientation.		
	11/7/2022 for short te				" The definition of newlect and the		
	abnormal gait, and a	led, unsteady on his feet,			" The definition of neglect and the to immediately notify the Administrate		
	abriorrial gait, and a				Director of Nursing of all issues relat		
	An admission Minimu	ım Data Set (MDS) dated			these infractions. If Administrator or	eu io	
		sident #1 was cognitively			Director of Nursing are not present in	h	
		king and reflected no pain			facility, supervisors must be notified,		
	present.				they must inform the Administrator of		
					Director of Nursing immediately in pe		
	A physical therapy no	ote dated 11/22/22 written by			or by phone.		
	Physical Therapy Ass	sistant (PTA) #1 revealed, on			" Our facility does not condone ar	nd has	
	multiple days ranging	from 11/22/22 through			zero tolerance for resident neglect by	у	
		1 had complained of pain in			anyone, including staff members,		
		diated down the calf with			physicians, consultants, volunteers,		
		The note further explained			of other agencies serving the resider	nt,	
		the PT and the Therapy			family members, legal guardians,	_	
		Resident #1's change of uded an assessment by the			sponsors, other residents, friends, or other individuals.		
		gait with scissoring feet			On 12/30/22-12/31/22, education wa		
		im assistance provided by			provided by the Director of Nursing,		
		(a stepping pattern where			Assistant Director of Nursing, Unit		
		attempting to move in a			Managers, or designee to all care sta	aff	
		ell as where hips are flexed			including CNA s, Nurses, Therapist		
		p) and LLE pain. The PT			and Nurse Practitioner regarding the		
	recommended an ord				definition of neglect, as defined in the		
	obtained to the LLE a	and spine.			neglect policy and the resident⊡s rig	ht to	
	The Nurse Practitione	er wrote an order dated			be free from neglect.		

Facility ID: 923004

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		MEDICAID SERVICES				D. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY
						С
		345080	B. WING		01/	04/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 3	F 60	00		
		an x-ray for the left hip and				
		btained for LLE pain and leg		Neglect is defined as failu	ure of the facility,	
	shortening.	-		it⊡s employees or service	•	
				provide goods and servic		
		w revealed a physician's		that are necessary to avo		
		for an x-ray for the left hip re to be obtained for LLE		mental anguish, or emotion	onal distress.	
	pain and leg shorteni			Staff to include the Nurse	Practitioner was	
				also educated 12/30/22-1		
	An x-ray report dated	11/23/22 indicated Resident		immediately address pair	n, complete	
	#1 had a radiological	study of the left hip and		assessments and treat pa	ain as directed by	
	lumbar spine on 11/2	2/22 which resulted with		the Physician or Physicia	n Extender	
	findings to include an			(Nurse Practitioner). Dire		
		fracture of the femoral neck.		Nursing/Assistant Directo		
	·	s usually associated with		Managers were educated		
		d fracture typically required		regarding the process of		
		for repair, sub-capital in the neck of the thigh		diagnostic orders until res obtained. This process in		
		s not signed by staff as being		diagnostics log implemen		
	received.	shot signed by stall as being		Director of Nursing utilizir	-	
				system to identify and do	-	
	A review of the medic	cal record of Resident #1		log all new orders created		
	revealed no notificati	on was made by facility staff		reviewed by Director of N		
	to the medical provid	er regarding the results of		Director of Nursing/Unit N	lanagers daily	
	Resident #1's x-ray p	performed on 11/22/22.		until results are obtained	to ensure	
				compliance and effective		
		ote dated 11/23/22 written by		including agency staff wil		
		sident #1 had increase		education prior to start of		
		with unsafe Trendelenburg attern, pain in the left knee		the definition of neglect a abuse/neglect reporting r		
		ne calf. PTA #1's note		including immediate inter	•	
		I nursing of Resident #1's		Director of Nursing and A		
		ld that an x-ray had been		be responsible to ensure		
		re and the results were		for all licensed staff mem	-	
		ne was requesting an order				
	for a urinary analysis	(UA) for increased		The Director of Nursing/E		
	confusion.			complete change of cond		
				(5) five times a week for (		
	An interview with PTA	A #1 on 12/30/22 at 11:00 AM		then (3) times a week for	(4) weeks to	1

Facility ID: 923004

		MEDICAID SERVICES				O. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY IPLETED	
			. Boilding	·		С	
		345080	B. WING		01/04/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
				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 OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Continued From page	► <b>/</b>	F 60	0			
1 000			FOU	-	aidanta		
		niliar with Resident #1 and		ensure there are no new re			
		on several days while in the		experiencing pain or other	-		
		ned she had provided Resident #1 on 11/22/22		significant changes without assessment and pending X			
		n in knee down to calf with			-ray results .		
		She indicated on 11/22/22		The Director of Nursing will	l he		
		an his baseline and during		responsible for implementin			
		oving his feet in a scissoring		corrective action.	ig the		
		is safety compromised. She					
		ne Physical Therapist was		The facility will be in full co	mpliance with		
		sident #1's ambulation and		this Plan of Correction no la			
		am of him and thought he		_			
		ogical studies. PTA #1 stated					
		made the Therapy Program					
		esident #1's condition being					
	-	knowledge an x-ray was					
		PTA #1 stated she worked					
		in on 11/23/22 when she					
	J J	ased confusion, continued to					
	complain of LLE pain	and ambulate in a					
	scissoring gait fashio	n. PTA #1 indicated she					
	spoke with the nurse	on the unit; however, she					
	could not recall which	n nurse, and was told an					
	x-ray had been order	ed but the result was not					
	available at the time a	and the nurse would request					
		analysis if the confusion					
		ated that was the last day					
		dent #1 because he was					
		apy services when he was					
	sent to the hospital fo	or a tractured hip.					
	A telephone interview	with the Physical Therapist					
	on 12/30/22 at 1:20 P						
	evaluated Resident #	1 on admission and had					
	provided therapy trea	tment on several days					
		facility. She explained					
	Resident #1 began ha						
	complaints of pain be						
		ginning with his whist about					

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					FORM	01/24/2023 APPROVED
OVIDER/SUPPLIER/CLIA	· /				(X3) DATE COMP	SURVEY LETED
345080	B. WING _					C 04/2023
	· · · · · ·	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE	•	
		22	20 13TH AVENUE PLACE N	w		
		Н	IICKORY, NC 28601			
T OF DEFICIENCIES BE PRECEDED BY FULL ITIFYING INFORMATION)	ID PREFIX TAG	x	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE CED TO THE APPROPRIA		(X5) COMPLETION DATE
#1 on 11/18/22 and ively got more of his stay in the ad performed a nt #1 when she possibility of nerve lood clot due to pain ing and abnormal normal and therefore n Manager with gical studies. The PT sident #1's leg lengths ed Resident #1 to s were pending tively participate in n. She indicated she ough unable to he x-ray results but nding. by Program Manager realed she was the and had not directly wever, had been ts of pain to his LLE ed on 11/22/22 she e concerns with his had made the Unit nmendation to obtain mine the changes further stated she ray had been ordered sults of a hip fracture y on 11/28/22 and en admitted to the	F	500				
	A 1 on 11/18/22 and ively got more of his stay in the ad performed a nt #1 when she possibility of nerve lood clot due to pain ing and abnormal normal and therefore n Manager with gical studies. The PT sident #1's leg lengths ad Resident #1 to s were pending ively participate in h. She indicated she ough unable to he x-ray results but ading. by Program Manager realed she was the and had not directly wever, had been ts of pain to his LLE ed on 11/22/22 she a concerns with his had made the Unit mendation to obtain mine the changes further stated she ray had been ordered sults of a hip fracture y on 11/28/22 and en admitted to the	OVIDER/SUPPLIER/CLIA       (X2) MULT         INTIFICATION NUMBER:       A. BUILDII         345080       B. WING_         GOF DEFICIENCIES       JD         PRECEDED BY FULL       PREFIL         TIFIYING INFORMATION)       PREFIL         TAG       PREFIL         THEYING INFORMATION)       PREFIL         TAG       PREFIL	OVIDER/SUPPLIER/CLIA       (X2) MULTIPLE         STIFICATION NUMBER:       A. BUILDING         345080       B. WING         345080       B. WING         Image: Control of the state of t	OVIDER/SUPPLIER/CLA INTIFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION A. BUILDING         345080       B. WING         STREET ADDRESS, CITY, STA 220 13TH AVENUE PLACE N HICKORY, NC 28601         IC OF DEFICIENCIES SE PRECEDED BY FULL TIFIFYING INFORMATION)       ID PREFIX FAG       PROVIDER'S. (EACH CORREC CROSS-REFEREND D         #1 on 11/18/22 and ively got more of his stay in the ad performed a nt #1 when she possibility of nerve lood clot due to pain ing and abnormal normal and therefore n Manager with gical studies. The PT ident #1's leg lengths ed Resident #1 to s were pending ively participate in h. She indicated she ough unable to he x-ray results but iding.       F 600         yP Program Manager realed she was the and had not directly wever, had been ts of pain to his LLE ed concrems with his had made the Unit nmendation to obtain mine the changes further stated she ray had been ordered uits of a hip fracture y on 11/28/22 and en admitted to the       ID PREFIX PREFIX PROVIDER'S PREFIX PROVIDER'S PREFIX PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PROVIDER'S PREFIX PROVIDER'S	OVIDER/SUPPLIER/CLIA INTFICATION NUMBER:       (2) MULTIPLE CONSTRUCTION A BUILDING         345080       B. WING         20 1311 AVENUE FLACE NW HICKORY, NC 28601         DEPRECEDED BY FULL THY ING INFORMATION)       D PREFIX TAG         F 600         #1 on 11/18/22 and ively got more of his stay in the ad performed a nt #1 when she possibility of nerve lood clot due to pain ing and abnormal normal and therefore n Manager with gical studies. The PT ident #1 is leg lengths ad Resident #1 to s were pending ively participate in a. She indicated she pugh unable to hex -ray results but dring.         y Program Manager ealed she was the and had not directly wever, had been ts of pain to his LLE e concerns with his had made the Unit mendation to obtain mine the changes fay had been ordered uults of a hip fracture y on 11/22/22 and en admitted to the	AID SERVICES     OMB NC       covidersupPLERCLIA NTFIFCATION NUMBER:     (x2) MULTIPLE CONSTRUCTION A BUILDING     (x3) DATE COMP       345080     B. WING     COMP       345080     B. WING     01/       20 13TH AVENUE PLACE NW HICKORY, NC 28601     STREETADDRESS, CITY, STATE, ZIP CODE 20 13TH AVENUE PLACE NW HICKORY, NC 28601       COF DEFICIENCIES BE PRECEDED BY FULL THEYING INFORMATION)     PD PREFIX TAG     PROVIDERS PLAN OF CORRECTION (EACA CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F1 on 11/18/22 and lively got more of his stay in the ad performed a th f1 when she possibility of nerve lood clot due to pain ing and abnormal normal and therefore n Manager with gical studies. The PT ident #1 to s were pending ively participate in . She indicated she sugh unable to he x-ray results but iding.     She indicated she sugh unable to he x-ray results but iding.       y Program Manager ealed she was the and had not directly wever, had been ts of pain to his LLE ad on 11/22/22 she e concerns with his had made the Unit mendation to obtain mine the changes further stated she an admitted to the     Image: She indicated she and made the Unit mendation to obtain mine the changes further stated she an admitted to the

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	): 01/24/2023 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345080	B. WING			_		C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				22	20 13TH AVENUE PLACE	NW		
THE GREI	ENS AT VIEWMONT			н	IICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	the one who obtained Resident #1 to have r hip and spine on 11/2 x-ray company to setu them completed. Nurse was notified by therap of condition to include therefore proceeded t process was to inform unit of the resident's of condition; however, sl informed on 11/22/22 radiological studies or in therapy and she did assessment of Reside strictly requested the of therapy staff. Nurse studies were complete the facility, and they the alerting them of abnor could not recall why re Resident #1's studies 24 hours after the x-ra she had not contacted to verify the result follo on 11/22/22. An interview with the 12/30/22 at 10:36 AM facility's routine NP. T Resident #1 and being staff member that req #1 due to complaints shortening. The NP re in Resident #1's medi had recorded a visit o review; however, had	ager in the facility and was the order the NP for adiological studies of the left 2/22 and called the local up the appointment to have as #4 indicated when she y of Resident #1's change pain in his LLE and o obtain orders. Her normal the nurse assigned to the orders or changes in the could not recall who she of the orders for the the concerns with changes a not perform a physical ent #1 at the time, but x-ray as a recommendation at #4 further stated after ed, the results were faxed to ypically receive a phone call mal results; however, she esults were not available for during the typical range of ay was obtained. She stated at the x-ray company herself owing the order being made Nurse Practitioner on revealed she was the he NP stated she recalled g informed on 11/22/22 by a uested x-rays for Resident of LLE pain and leg eviewed her documentation cal record and stated she in 11/22/22 for a medication	F	600				

Facility ID: 923004

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	-	D HUMAN SERVICES MEDICAID SERVICES	-			FORM	): 01/24/2023 1 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE COMP	LETED
		345080	B. WING		_		_ 04/2023
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE GRE	ENS AT VIEWMONT			20 13TH AVENUE PLACE HCKORY, NC 28601	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	assessed Resident # orders, an addendum in her note on 11/22/2 not on duty during the 11/28/22 due to the he evening of 11/27/22 s medical record of Res x-ray results which re She called the facility Resident #1 had retur nursing staff that answ knowledge of the x-ra she would expect the of all abnormal x-ray in not feel as though the through 11/27/22 was time for Resident #1 t intervention for a hip t the facility had on-call notification of abnorm NP also indicated she went without any pain 11/22/22 through 11/2 was not an expert wit specify how the injury may have been possi because of an undete crumbled with increas resulting in a complet time. The NP said bee him, she could not sp treatment plan other t A physical therapy no the PT indicated Resi continued pain to his aware and informed t	he NP stated if she had 1 after the request of the would have been included 22. The NP stated she was a period of 11/23/22 through olidays; however, late on the he was reviewing the sident #1 and discovered the vealed a left hip fracture. on 11/28/22 to see if med to the facility and wered the phone had no y results. The NP stated facility to inform a provider results immediately and did e delay from 11/22/22 an appropriate length of o go without medical fracture. The NP indicated I services 24/7 for al results and orders. The e was not aware Resident #1 management from 28/22. The NP indicated she h orthopedics and could not occurred; however, stated it ble the injury occurred ected hairline fracture which se weight bearing activities e break in a short period of cause she did not assess eak to his leg shortening or han she ordered the x-ray.	F 600				

Facility ID: 923004

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/24/2023 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345080	B. WING			_		C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
				22	20 13TH AVENUE PLACE	NW		
THE GREE	ENS AT VIEWMONT			H	ICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page which nurse she mad		F 6	00				
	PTA #2 indicated Res participate in ambulat to having pain in the L #7) was notified of the time.	ion exercises in therapy due LE. The hall nurse (Nurse ongoing concern at the						
	Allempts to interview	PTA #2 were unsuccessful.						
	Attempts to interview unsuccessful.	Nurse #7 were						
	pain assessment was	#1's medical record lected a comprehensive completed besides what is owing the complaints made						
	Administration Record #1 received schedule (milligrams) every 8 h 11/22/22 for joint pain receive any additional reported pain in thera pain to nursing staff fr through the morning of when he received a ti mg and Tylenol 1000 before transferring hir (ER) for evaluation of The November MAR	ours from 11/15/22 through . Resident #1 did not I pain medication for py and mild complaints of om the evening of 11/22/22 of 11/28/22 at 12:12 AM me order for Norco 5/325 mg to be administered n to the emergency room a left hip fracture.						
	pain level #1, 11/12 p level #1 on 2nd. No fu	umented as follows: 11/8 ain level #2 on days and irther pain was documented ¢1 on both 1st and 2nd.						

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	): 01/24/2023 MAPPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345080	B. WING		_		C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE GRE	ENS AT VIEWMONT			220 13TH AVENUE PLACE HICKORY, NC 28601	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	level #1 on 1st and 2r 1st and level #3 on 2r A physician's order er 11/28/22 at 12:07 AM Tylenol 500 mg (2 tab Norco 5/325 mg NOW An Interact note (char written by Nurse #1 d Resident #1 was disc abnormal x-ray with a He was then transferr Whitener- niece) was A nurses note dated 1 indicated the hospital facility regarding the x treatment for 6 days a knowledge of the x-ra the resident until that An Emergency Room indicated the hospital about the delay in trea performed on 11/22/2 through the cracks" a were not interpreted, days following the stu being on vacation. Th Resident #1 had a dis femoral neck fracture (computer tomograph radiological study who x-ray).	s and level #2 on 2nd. Resident #1 reported pain ad and on 11/27 level #2 on ad. htered by Nurse #3 on indicated the following: lets) x 1 dose NOW and / for pain. nge of condition form) ated 12/28/22 indicated harged to the hospital for an pain level #9 to the left hip. ed and the next of kin (Kim notified of transfer. 1/28/22 written by Nurse #1 called to question the start, fracture, and delayed and the nurse had no y, or any concerns related	F 600				

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	2: 01/24/2023 APPROVED 0: 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	345080	B. WING			( 01/0	C 04/2023
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
		2	20 13TH AVENUE PLACE N	w		
THE GREENS AT VIEWMONT		н	IICKORY, NC 28601			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
the documentation pro indicated Resident #1 a left hip and lumbar s obtained by staff on 11 resulted in an acute, tr subcapital fracture of t 11/23/22 at 1:55 AM. T results had been faxed placed to the facility; h include who the Dispat of the call and no furth this record for this stud A telephone interview at 9:40 AM revealed sl on duty on both the ev evening of 11/27/22 ar PM-7:00 AM shifts. Nu not informed during sh order was obtained on to have radiological stu had complained of pain studies had been perfor not recall him complain assess him. Nurse #1 duty on the evening of received a phone call of the facility's nurse prace Resident #1's condition she reviewed in his me fracture, and to see if the Nurse #1 stated she re	was admitted to the e to the left hip with ar surgery pending. with a Dispatcher from 29/22 at 3:08 PM revealed vided in their records had a radiological order for pine studies which were /22/22 at 11:55 PM and ansverse, displaced, he femoral neck on The dispatcher indicated d to the facility and a call owever, the notes did not tcher spoke with at the time er details were included in dy. with Nurse #1 on 12/30/22 he was the nurse who was ening of 11/22/22 and the nd typically worked 7:00 rrse #1 indicated she was iff-to-shift report that an 11/22/22 for Resident #1 udies performed, that he n, nor whether radiological ormed at the time. She did hing of pain and she did not also indicated she was on 11/27/22 when she very late in the shift from ctitioner (NP) questioning n due to the x-ray results edical record of the	F 600				

Facility ID: 923004

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/24/2023 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345080	B. WING		-		C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
			2	20 13TH AVENUE PLACE	NW		
THE GREE	ENS AT VIEWMONT		H	IICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 600	Continued From page help locate the radiolo Resident #1 on 11/22, revealed an acute, tra subcapital fracture of stated she and Nurse room during the phon his pain and was told time. Nurse #1 did no physical assessment asked him about his p both she and Nurse # and received orders fit medications and send immediately for evalue collected needed pap called Emergency Me A telephone interview at 9:49 AM revealed se evening shift (7:00 PM and recalled Nurse #1 x-ray results that were 11/22/22. Nurse #2 st she was able to locate #1's studies which rev sustained an acute, tr subcapital fracture of stated the NP became Resident #1 was still if a fractured hip. Nurse provided direct care to timeframe and had no being ordered or why placed for the left hip	e 11 pojical studies performed on /22 and found the report insverse, displaced the femoral neck. Nurse #1 #2 went to Resident #1's e call and asked him about he had some pain at the t recall if she performed any for Resident #1 other than bain. Nurse #1 indicated 2 returned to the telephone from the NP to provide pain I Resident #1 to the ER ation. Nurse #1 stated she erwork while Nurse #2 dical Services to the facility. with Nurse #2 on 12/30/22 she was on duty on the A to 7:00 AM) on 11/27/22 I asked her to help her find e ordered by the NP on ated after some difficulty, e the results for Resident /ealed Resident #1 had	F 600	D		TE	DATE
	room that night after r the NP and stated Re	all went to Resident #1's eceiving the phone call from sident #1 complained of he time. Nurse #2 did not					

Facility ID: 923004

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/24/2023 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION			LETED
		345080	B. WING		_		C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			2	20 13TH AVENUE PLACE	NW		
THE GREE	ENS AT VIEWMONT		F	IICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	for Resident #1 other pain. Nurse #2 stated Resident #1 to the en evaluation immediate A telephone interview at 9:59 AM revealed s duty on the evening of and Nurse #2 gained studies for Resident # fracture. Nurse #3 ind several days during th through 11/27/22 and #1 had x-rays ordered fracture. Nurse #3 state direct care for Reside pain management dur	d any physical assessment than asked him about his she called EMS to transfer nergency room for ly. with Nurse #3 on 12/30/22 she was the supervisor on f 11/27/22 when Nurse #1 knowledge of radiological #1 which included a left hip licated she had worked ne timeframe of 11/22/22 had no knowledge Resident d and resulted in a hip ted she did not provide nt #1 and could not address ring that time. Nurse #3 vere received from the x-ray	F 600				
	placed in the provider	the provider, the copies 's binder located at the e on-coming nurses to pending x-ray results.					
	PM revealed she had during his stay; howe dates. Nurse #5 indic notified by a member complained of pain du some slight swelling i #5 stated therapy had and offloaded his LLE Manager about the x- unable to locate them According to Nurse #3 Manager that the resu	se #5 on 12/30/22 at 12:00 worked with Resident #1 ver, could not verify which ated she recalled being of therapy that he had uring his treatment and had n his lower extremity. Nurse I placed him back in bed I's and she asked the Unit ray results since she was in his medical record. 5, she was told by the Unit ults were still pending, and him pain medication but					

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	-	D HUMAN SERVICES					FORM	): 01/24/2023 MAPPROVED ). 0938-0391	
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345080	B. WING					C 04/2023	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	E, ZIP CODE			
				22	20 13TH AVENUE PLACE N	w			
THE GREE	ENS AT VIEWMONT			н	IICKORY, NC 28601				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRI		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE			
F 600	have been waiting for medication at the time A telephone interview at 12:45 PM revealed Resident #1, however x-ray being ordered e when the x-ray was of knowledge of what tim time looked for a resu exam of Resident #1 LLE shortening. Nurse in pain. An interview with the on 1/4/22 at 10:30 AM aware of Resident #1 <sup>1</sup> left hip fracture when 11/28/22 and was not to the hospital. The D typically all x-ray repo hours following the x-l could not explain why imaging company who be pending after 24 he assessment of the on potential LLE shorten these would be expect medical record with all condition. The Administrator was	ed on the MAR she may an order for additional e if none was ordered. with Nurse #6 on 12/30/22 she was familiar of r, she could not recall the ven though she was on duty btained, she had no ne it was obtained and at no lt or performed a physical secondary to his pain or e #6 did not recall him being Director of Nursing (DON) A revealed she had become 's x-ray which resulted in a she arrived at the facility on ified he had been admitted ON further explained rts are obtained within 24 ray being performed but staff had not contacted the en the results continued to ours nor why no formal going complaints of pain or ing had been performed as sted to be included in the	F	600	DE	FICIENCY)			
	o Identify those recipi	ents who have suffered, or serious adverse outcome as npliance							

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(X3) DATI		
	(X3) DATE SURVEY COMPLETED	
01	C / <b>04/2023</b>	
DBE	(X5) COMPLETION DATE	
	ON D BE PRIATE	

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	-	D HUMAN SERVICES					FORM	01/24/2023
STATEMENT	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345080	B. WING			_		C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE GRE	ENS AT VIEWMONT				20 13TH AVENUE PLACE IICKORY, NC 28601	NW		
(X4) ID PREFIX TAG			ID PREFI TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	On 12/31/22 educatio Human Resources Di regarding the definitio education to all new h during orientation. " The definition of h immediately notify the issues related to these Administrator or DON supervisors must be r inform the Administrat person or by phone " Our facility does tolerance for resident including staff member volunteers, staff of oth resident, family mem sponsors, other reside individuals. On 12/30/22 - 12/31/2 by the DON, ADON, It to all care staff to inclu Therapist, and Nurse definition of neglect, a policy and the resider neglect. "Neglect" is defined a employees or service and services to a resi avoid physical harm, f emotional distress. Staff, to include the N educated 12/30/22 - 1	n was provided to the rector by the Administrator in of neglect and including irres/Agency direct care staff neglect 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 not condone and has zero neglect by anyone, ers, physicians, consultants, her agencies serving the abers, legal guardians, ents, friends, or other 2, education was provided Unit Managers or designee, ude CNA's, Nurses, Practitioner regarding the as defined in the neglect at's right to be free from s failure of the facility, its s providers to provide goods dent that are necessary to	F	600				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	): 01/24/2023 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345080	B. WING			_		C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				2	20 13TH AVENUE PLACE	NW		
THE GREI	ENS AT VIEWMONT			F	HICKORY, NC 28601			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 600	Extender (Nurse Prace Mangers were educat the process of trackin until results are obtain a diagnostics log impl utilizing the EMAR sy document on the log a day and reviewed by daily until results are of compliance and effect agency staff will recei start of the shift to inc and the abuse/neglect including immediate in nursing and administr ensure this is complete members	e Physician or Physician titioner). DON/ADON/Unit ted on 11/28/22 regarding g pending diagnostic orders ned. This process includes emented by the DON stem to identify and all new orders created each DON/ADON/Unit Managers obtained to ensure tiveness. All staff, including we education prior to the lude the definition of neglect t reporting requirements ntervention. The Director of ator will be responsible to ted for all licensed staff	F	600				
	as outlined above, ed staff to include the Nu completed in person a ADON, Unit Manager education consisted o " The definition of the issues related to these Administrator or DON supervisors must be r inform the Administration person or by phone " Signs and sympton anguish such as loss routine, change of con to pain), mood alteration	and via phone by the DON, s or Designee. The of the following: neglect 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 neglect and mental of interest, change in ndition (specifically related ions, or difficulty eating. not condone and has zero						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/24/2023 MAPPROVED D. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345080	B. WING _				C 04/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	ENS AT VIEWMONT			22	20 13TH AVENUE PLACE NW		
				н	IICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TIVE ACTION SHOULD BE CON ICED TO THE APPROPRIATE	
F 600	volunteers, staff of oth resident, family men sponsors, other reside individuals. " the education for condition, specifically ensure x-ray results w This training will be pro or the Human Resour staff and new employ orientation. All direct as-needed and agence on 12/30/22 - 12/31/2 to receive the training Administrator and Hu were notified by the F Operations of the nee new hires on 12/30/22 Alleged IJ removal da The credible allegation 1/1/23 was validated verbalize the definition examples as well as w the Administrator or D with any concerns of potential of neglect. S provide written statem or reports made by a family member to the immediately. Staff voo the updated processe	ers, physicians, consultants, her agencies serving the hbers, legal guardians, ents, friends, or other cused on changes in related to pain and to vere received and reported. rovided by the Administrator rece Director to all agency ees upon hire during care staff including cy staff, received this training 2 and all staff will continue yearly thereafter. The man Resource Director Regional Director of ed to provide this training to 2. the is 1/1/23. In with an IJ removal date of on 1/4/23. Staff were able to ns of neglect and provided vocalize they were to contact DON via phone or in person observed or reported Staff report they are to hents of their observations resident, staff member, or facility Administrator calized and demonstrated es for obtaining and reporting	F	600			
F 684 SS=J	with all acute changes Quality of Care	and documentation required s to a resident.	F	684			1/5/23

Facility ID: 923004

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F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	. ,	ATE SURVEY OMPLETED
					С
	345080	B. WING			01/04/2023
ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STAT	E, ZIP CODE	
INS AT VIEWMONT				w	
			HICKORY, NC 28601		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	IVE ACTION SHOULD BE ED TO THE APPROPRIATE	(X5) COMPLETION DATE
Continued From page	<b>-</b> 18	E 68			
	5.10	FUC	14		
facility residents. Based on the comprehensive					
	-				
accordance with profe	essional standards of				
practice, the compreh	nensive person-centered				
care plan, and the res	sidents' choices.				
This REQUIREMENT	is not met as evidenced				
	-		F684 $\square$ Quality of C	are	
•			Dranaration aubmio	aion and	
			-		
	•		0		
• •					
x-ray was ordered on	11/22/22 with results		means to continuous	ly improve the quality	
reported to the facility	/ on 11/23/22, which noted		of care and to compl	y with all the	
•	-		-		
	-				
÷ ,	-				
-	-		the resident.		
	-				
, –			-		
				suttering from the	
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page CFR(s): 483.25 § 483.25 Quality of car Quality of care is a fur applies to all treatment facility residents. Bass assessment of a resident that residents received accordance with profi- practice, the compreti- care plan, and the rest This REQUIREMENT by: Based on record rev Practitioner, x-ray con- staff interviews, the fa- comprehensive assest the Unit Manager and made aware the resid- left extremity pain on- to have shortening of x-ray was ordered on- reported to the facility an acute, transverse, fracture (a transverse, fracture (a transverse, ith major force, disp- required surgical inter sub-capital meaning i- thigh bone). The x-ra- up on or acknowledg- completed and the re- pain during therapy. I- treatment were initiat Practitioner called the 11/27/22 and reported Resident #1 reported of 9 to 10 (10 being therapy). I- transferred to the host	345080         ROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 18 CFR(s): 483.25         § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	A BUILDING         BUMMARY STATEMENT OF DEFICIENCIES         INTERCISE SUMMARY STATEMENT OF DEFICIENCIES         INTERCIPENT IS INFORMATION)         INTERCIPENT IS INTERCIPENT         INTERCIPENT IS NOT THE AS EVALUATION         INTERCIPENT IS NOT THE AS EVALUATION	345080         B. WING           CONDER OR SUPPLIER         STREET ADDRESS, CITY., STAT 220 13TH AVENUE PLACE N HICKORY, NC 28601           INS AT VIEWMONT         STREET ADDRESS, CITY., STAT 220 13TH AVENUE PLACE N HICKORY, NC 28601           ID         PROVIDERS F (EACH OFFICIENCY MUST GE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION)         ID           Continued From page 18 CFR(s): 483.25         F 684         PROVIDERS F (EACH CORRECT CROSS-REFERENC CROSS-REFERENC DE           2 (3 433.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, and family, Nurse Practitioner, x-ray company representative, and stafi interviews, the facility failed to provide comprehensive assessments for a resident when the Unit Manager and Nurse Practitioner were mada aware the resident had complaints of lower left extremity pain on 11/22/22 with results reported to the facility on 11/22/22 with results reported to the facility on 11/22/22 with results reported to the facility on 11/22/22 with results requirements. Corre accompliched for the practice by facility sti comprehensive asses ignificant change in the neck of the trigh bone). The x-ray results were not followed up on or acknowledged after the x-ray was completed and the resident continued to report pain during therapy. No medical evaluation or treatment were initiated until the Nurse Practitioner called the facility near midningh ton 11/27/22 and reported	345080     b. WING       INS AT VIEWMONT     Z20 13TH AVENUE PLACE NW HICKOPY, NC 28601       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NUST BE PRECEDED BY FULL REQUATORY OR LSC IDENTIFYING INFORMATION)     D PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NUST BE PRECEDED BY FULL REQUATORY OR LSC IDENTIFYING INFORMATION)     D PREFIX TAG       Continued From page 18 CFR(s): 483.25     F 684       Continued From page 18 CFR(s): 483.25     F 684       S 43.35 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident Ad complaints of lower Practitioner, x-ray company representative, and staff interviews, the facility mate as evidenced by: Based on record reviews, and family, Nurse Practitioner, x-ray company representative, and staff interviews, the facility on 11/22/22 with results reported to the facility on 11/22/22 with results reported to the facility on 11/22/22 withic hoted ra acute, transverse, displaced left femoral neck fracture (a transverse) transverse, displaced left femoral neck fracture (a transverse) transverse, displaced left femoral neck fracture (a transverse) with agol cacure to thick the scalar south the facts and conclusions set forth on the survey report. Cur Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to completing a comprehensive assessment and neok of the freatment including pain interventions for the resident.       Residen #1 reported the the pacit ID year yesults to staff. R

Facility ID: 923004

	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MUL	TIPLE C	CONSTRUCTION		<u>0. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,				PLETED
		345080	B. WING			01	C / <b>04/2023</b>
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT VIEWMONT		220 13TH AVENUE PLACE NW HICKORY, NC 28601				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 684	Continued From page	e 19	F	684			
	residents reviewed for (Resident #1). The Immediate Jeop when Resident #1 co extremity pain and ex gait during therapy al interventions were no jeopardy was remove implemented a credit jeopardy removal. Th compliance at lower a actual harm that is im	ot provided. The immediate ed on 1/1/23 when the facility ble allegation of immediate ne facility will remain out of scope and severity "D" (no nmediate jeopardy) to and to ensure monitoring			On 11/28/22-11/30/22, the deficient practice was identified, and a self-imposed plan of correction was initiated. The facility retains complian as it related to the monitoring of X-ra All other residents were assessed for undocumented, unreported or unkno changes in condition that would resu change in the resident plan of care including physician notification, thoro assessment and medical intervention Unit Managers or designee on 12/30/22-12/31/22. No other resident were identified.	ys. wn It in a ugh ı by	
	11/7/2022 for short te diagnosis that include vascular dementia, a of falls. An admission Minimu 11/14/22 indicted Res	nitted to the facility on erm rehabilitation with ed, unsteadiness of his feet, bnormal gait, and a history um Data Set (MDS) dated sident #1 was cognitively aking and reflected no pain			On 11/28/22 an audit of all X-Rays ordered in the last 14 days was completed, no concerns were found. On 11/28/22 education was provided Nurses by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or designee on reporting o ordered X-Ray results immediately to Director of Nursing or designee. On 11/28/22 Director of Nursing requested a Plan of Correction from the	of all	
	the Physical Therapis complained of left kn which was reduced w swelling of the knee The note further indic	ote dated 11/18/22 written by st (PT) indicated Resident #1 ee pain with movement when at rest as well as was noted upon examination. cated the Therapy Program sing staff of the change in on.			X-Ray provider in relation to no verba notification of acute X-Ray findings a as correction of fax number and crea of a pop-up screen with Director of Nursing contact information when no answer at the facility to assure notific On 11/28/22 and ongoing, all X-Rays be reported to the Director of Nursing	al s well tion cation.	

Event ID: WQDM11

Facility ID: 923004

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	S FOR MEDICARE &		0.00		OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	2	с
		345080	B. WING		01/04/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	
				220 13TH AVENUE PLACE NW	
INE GREI	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) CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE
F 684	Continued From page	20			
F 004			F 68		
		te dated 11/22/22 written by		designee when ordered	
		sistant #1 (PTA) indicated		followed up daily until re	
		plained of pain in the left down the calf with certain		X-Rays will be listed and	
				whiteboard each mornin	
		e further explained PTA #1 sical Therapist (PT) and the		meeting as well as the N office and documented	
		nager of Resident #1's		until results are received	
		The assessment by the PT			1.
		revealed Resident #1 had		The Director of Nursing	was educated on
		ith scissoring feet patterns		12/30/22 by the Regiona	
		ance provided by staff (a		Education provided was	
		re the feet cross when		related to the change of	
		prward and hips flex upward		(specifically related to pa	
		d posture, and LLE pain.		process of tracking pend	
		d an order for an x-ray to be		tracking log to ensure co	
	obtained to the LLE a	-		effectiveness. The Assis	-
				Nursing and Unit Manag	
	The Nurse Practitione	er wrote an order dated		educated by the Directo	
		an x-ray for the left hip and		12/30/22. Education pro	5
		ptained for LLE pain and leg		specifically related to ch	
	shortening.			(specifically related to pa	•
				process of tracking pend	
	An x-ray report dated	11/23/22 indicated Resident		tracking log to ensure co	
	#1 had a radiological	study of the left hip and 2/22 which resulted with		effectiveness.	
	findings to include an			On 12/30/22-12/31/22 a	II direct care staff
		fracture of the femoral neck.		were educated to includ	e Therapy staff by
		s usually associated with		the Director of Nursing,	Assistant Director
		d fracture typically required		of Nursing, Unit Manage	
	surgical intervention f			immediately report chan	
		n the neck of the thigh		(specifically related to pa	
	, .	not signed by staff as being		changes in appearance	
	received.			anatomy) including char	-
				ADL, or participation in a	
		al record of Resident #1		or other usual patterns t	
		on was made by facility staff		This education including	
	-	er regarding the results of		as well as non-verbal in	e e
	Resident #1's x-ray p	erformed on 11/22/22.		grimacing, withdrawing,	mental status
				changes, etc. for those i	

Event ID: WQDM11

Facility ID: 923004

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			0.00				<u>). 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		DNSTRUCTION		E SURVEY PLETED
			A. BUILDING	G			
		245080	B. WING				С
		345080	B. WING			01	/04/2023
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
THE GRE	ENS AT VIEWMONT				13TH AVENUE PLACE NW		
				HICI	KORY, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 684	Continued From page	e 21	F 68	34			
		te dated 11/23/22 written by		-	not be able to verbalize a change in		
		ident #1 had increase			condition including but not limited to		
		with unsafe Trendelenburg			increased pain. Nurse Practitioner wa	s	
		attern, pain in the left knee			educated on the expectation and		
	which radiated into th	e calf. PTA #1's note		i	mportance of completing assessmen	ts	
		nursing of Resident #1's		\	when notified of change in condition		
		d that an x-ray had been		6	and/or pain.		
		re and the results were					
		ne was requesting an order			All licensed nurses working and the N		
	for a urinary analysis	(UA) for increase confusion.			Practitioner were educated on thoroug	gh	
		\#1 on 12/30/22 at 11:00 AM			assessments related to change in		
	revealed she was fan			condition and/or pain; and reporting to Physician or Physician Extender (Nur			
		on several days while in the			Practitioner) immediately on	50	
		ined she had provided			12/30/22-12/31/22 by Director of Nurs	ina	
		Resident #1 on 11/22/22			Assistant Director of Nursing, Unit	ing,	
		n in knee down to calf with			Manager or designee. All other licens	ed	
	· ·	She indicated on 11/22/22			staff members who were not present,		
		an his baseline and during			ncluding agency staff, new hires and	new	
		oving his feet in a scissoring			agency staff will receive education an		
	motion which made h	is safety compromised. She		t	training by the Director of Nursing,		
		ne Physical Therapist was		/	Assistant Director of Nursing, Unit		
		sident #1's ambulation and			Managers, or designee to include abo	ve	
		am of him and thought he		i	nformation prior to returning to work.		
		ogical studies. PTA #1 stated					
		made the Therapy Program			The Director of Nursing/Designee will	I - 11 -	
	-	esident #1's condition being			complete change of condition audits o	-	
		knowledge an x-ray was			(5) five times a week for (4) four week		
		PTA #1 stated she worked in on 11/23/22 when she			then (3) times a week for (4) weeks to ensure no new residents are experier		
	_	ased confusion, continued to			pain or other signs of significant chan	•	
	complain of LLE pain	-			without an assessment and pending >		
		n. PTA #1 indicated she			results.	. ruy	
		on the unit; however, she		'			
	-	nurse, and was told an			The Director of Nursing will be		
		ed but the result was not			responsible for implementing the		
	-	and the nurse would request			corrective action.		
		analysis if the confusion					
		ated that was the last day			The facility will be in full compliance w	/ith	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED	
		345080	B. WING		0,	C 1/04/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		110-112020	
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 PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 684	discharged from thera sent to the hospital for A telephone interview on 12/30/22 at 1:20 P evaluated Resident # provided therapy trea during his stay at the Resident #1 began ha complaints of pain be a week after admission acute changes to Res the pain to his LLE pr intense over the rema facility. The PT stated couple brief tests on P initially thought there impingement or a pos in the knee with weigil gait, but the test was notified the Therapy P recommendations of could not recall wheth varied, but stated she continue therapy whill because he continued despite some reports had asked a hall nurs	dent #1 because he was apy services when he was ar a fractured hip. If with the Physical Therapist PM revealed she had 1 on admission and had tment on several days facility. She explained aving periodic vague ginning with his wrist about on; however, she noticed sident #1 on 11/18/22 and ogressively got more ainder of his stay in the d she had performed a Resident #1 when she was a possibility of nerve ssible blood clot due to pain ht bearing and abnormal not abnormal and therefore Program Manager with radiological studies. The PT her Resident #1's leg lengths a allowed Resident #1 to e x-rays were pending d to actively participate of pain. She indicated she	F 68		than		
	on 12/30/22 at 11:50 Therapy Program Ma worked with Resident made aware of his co and abnormal gait. St	Therapy Program Manager AM revealed she is the nager and had not directly #1; however, had been mplaints of pain to his LLE ne stated on 11/22/22 she e of the concerns with his					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/24/2023 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			LETED
		345080	B. WING		_		C 04/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE GRE	ENS AT VIEWMONT			20 13TH AVENUE PLACE HICKORY, NC 28601	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Manager aware of the a radiological study to noticed during therapy was later made aware but was not aware of until she arrived at the learned Resident #1 h hospital. A physical therapy no PTA #2 indicated Res continued pain to his aware which informed related to arthritic cha A physical therapy no PTA #2 indicated Res participate in ambulat pain secondary to ong hall nurse was notified the time. A review of the Nover Administration Record #1 received no medic 11/22/22 through 11/2 AM, received a 1-time and Tylenol 1000 mg before transferring hir (ER) for evaluation of The November MAR Record) had pain doo pain level #1, 11/12 p level #1 on 2nd. No fu until 11/22 with level # shifts, 11/25 level #3 of	nd she had made the Unit e recommendation to obtain o determine the changes y. She further stated she e an x-ray had been ordered the results of a hip fracture e facility on 11/28/22 and had been admitted to the te dated 11/24/22 written by ident #1 had reported LLE and nursing was made d therapy the pain was inges. te dated 11/25/22 written by ident #1 refused to ion exercises in the therapy going pain in the LLE. The d of the ongoing concern at mber 2022 Medication d (MAR) revealed Resident ations for pain from 27/22. On 11/28/22 at 12:12 e order for Norco 5/325 mg which was administered in to the emergency room	F 684				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/24/2023 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345080	B. WING		_		C 04/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE GRE	ENS AT VIEWMONT			20 13TH AVENUE PLACE IICKORY, NC 28601	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	reported pain level #1 and on 11/27 level #2 second shift. A physician's order er 11/28/22 at 12:07 AM Tylenol 500 mg (2 tab Norco 5/325 mg NOW A review of Resident a revealed no notes refi pain assessment to ir completed besides ev routinely listed on the complaints made in th An Interact note (char written by Nurse #1 d Resident #1 was disc abnormal x-ray with a A nurses note dated 1 indicated the hospital facility regarding the x treatment for 6 days a knowledge of the x-ra the resident until that A hospital History and indicated Resident #1 on 11/28/22 after it wa he had a left femoral ordered on 11/22/22 ft then. During the ER ef femur was confirmed, admitted to the hospital hip with orthopedic ar	on first and second shift on first shift and level #3 on indicated the following: olets) x 1 dose NOW and V for pain. #1's medical record lected a comprehensive neclude LE shortening was very shift pain levels MAR following the nerapy on 11/22/22. mge of condition form) ated 11/28/22 indicated harged to the hospital for an pain level #9 to the left hip. 11/28/22 written by Nurse #1 called to question the k-ray, fracture, and delayed and the nurse had no by, or any concerns related	F 684				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/24/2023 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345080	B. WING		-		C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
				220 13TH AVENUE PLACE	w		
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 PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	about the delay in treat performed on 11/22/2 through the cracks" at were not interpreted, i days following the stut being on vacation. Th Resident #1 had a dis femoral neck fracture (computer tomograph radiological study whe image). An interview with the 12/30/22 at 10:36 AM facility's routine NP. T Resident #1 and bein staff member that req #1 due to complaints shortening. The NP re in Resident #1's medi had recorded a visit of review; however, had documentation related nor leg shortening. Th assessed Resident #1' orders, an addendum in her note on 11/22/2 not on duty during the 11/28/22 due to the he evening of 11/27/22 s medical record of Res x-ray results which re She called the facility Resident #1 had retur nursing staff that answ knowledge of the x-ra she would expect the	had contacted the facility atment following the x-ray 2 and was told "he slipped nd therefore the results nor treatment initiated for 6 dies due to the provider e report further indicated splaced and impacted left and recommended a CT y study- a more detailed ere a computer guides the Nurse Practitioner on revealed she was the The NP stated she recalled g informed on 11/22/22 by a uested x-rays for Resident of LLE pain and leg eviewed her documentation cal record and stated she n 11/22/22 for a medication not included any d to the complaints of pain he NP stated if she had 1 after the request of the would have been included 22. The NP stated she was e period of 11/23/22 through olidays; however, late on the he was reviewing the sident #1 and discovered the vealed a left hip fracture. on 11/28/22 to see if	F 684				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	): 01/24/2023 MAPPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345080	B. WING			_		C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				2	20 13TH AVENUE PLACE	NW		
THE GRE	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 PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	time for Resident #1 t intervention for a hip f the facility had on-call notification of abnorm NP also indicated she went without any pain 11/22/22 through 11/2 was not an expert with specify how the injury may have been possif because of an undete crumbled with increas resulting in a complete time. The NP said bee him, she could not spe treatment plan other t The NP could not reca assessed and genera been leaving or some when staff approache specifically recall why before giving the orde An interview with a dis company on 12/29/22 documentation provid Resident #1 had a rac and lumbar spine stud staff on 11/22/22 at 11 acute, transverse, dis of the femoral neck or dispatcher indicated r facility and a call place the notes included dic dispatcher spoke with	a delay from 11/22/22 an appropriate length of o go without medical fracture. The NP indicated services 24/7 for al results and orders. The was not aware Resident #1 management from 8/22. The NP indicated she h orthopedics and could not occurred; however, stated it ble the injury occurred oted hairline fracture which weight bearing activities e break in a short period of cause she did not assess eak to his leg shortening or han she ordered the x-ray. all why Resident #1 was not lly stated she could have thing other patient care d her but could not she did not assess him ers. spatcher from x-ray at 3:08 PM revealed the ed in their records indicated diological order for a left hip dies which were obtained by 1:55 PM and resulted in an placed, subcapital fracture in 11/23/22 at 1:55 AM. The esults had been faxed to the ed to the facility; however,	F	684				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/24/2023 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		345080	B. WING					C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
				22	20 13TH AVENUE PLACE NV	v		
THE GREE	ENS AT VIEWMONT			н	IICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	27	F	684				
	An interview with Nur	se #1 on 12/30/22 at 9:40						
		the nurse who was on duty						
		f 11/22/22 and the evening						
	••	ally worked 7P-7A shifts.						
		e was not informed during It an order was obtained on						
		#1 to have radiological						
		at he had complained of						
	-	ological studies had been						
	•	. Nurse #1 also indicated						
	-	e evening of 11/27/22 when						
	from the facility's nurs	call very late in the shift						
	-	#1's condition and if he was						
		Nurse #1 asked further						
		as unable to answer, Nurse						
	· ·	ed assistance from another						
		me (Nurse #2) who was						
		ological studies performed						
		/22/22 resulted in an acute, subcapital fracture of the						
		1 stated she and Nurse #2						
		room during the phone call						
		his pain and was told he						
	•	time. Nurse #1 did not recall						
		ohysical assessment for						
	Nurse #1 indicated bo	n asked him about his pain.						
		one and received orders						
		e pain medications and						
		he ER immediately for						
		stated she collected needed						
	paperwork while Nurs (EMS) to the facility.	e #2 called paramedics						
	An interview with Nur	se #2 on 12/30/22 at 9:49						
		on duty on the evening shift						
		hen Nurse #1 asked her to						

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CENTER	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE			FORM	0: 01/24/2023 A APPROVED 0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				· /	LETED
		345080	B. WING		_		C 04/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE GRE	ENS AT VIEWMONT			20 13TH AVENUE PLACE IICKORY, NC 28601	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	about an x-ray, she ha Nurse #2 stated after able to locate the resu which revealed Resid acute, transverse, dis the femoral neck. Nur became upset and qu was still in the facility hip. Nurse #2 stated s care to Resident #1 d had no knowledge of why interventions had hip fracture until that to Nurse #1, and the nig #3) all went to Reside receiving the phone of Resident #1 complain the time. Nurse #2 did any physical assessm than asked him about she completed some called EMS to transfe evaluation immediate An interview with Nurse AM revealed she was the evening of 11/27/2 Nurse #2 gained know studies for Resident # fracture. Nurse #3 ind several days in during through 11/27/22 and #1 had x-rays ordered hip fracture. Nurse #3 direct care for Reside pain management du stated she could reca	NP called asking questions ad ordered on 11/22/22. some difficulty, she was ults for Resident #1's studies ent #1 had sustained an placed subcapital fracture of se #2 stated the NP restioned why Resident #1 at the time with a fractured she had not provided direct uring that time frame and the studies being ordered or I not been placed for the left time. Nurse #2 stated she, ht shift supervisor (Nurse ent #1's room that night after all from the NP and stated red of back and hip pain at d not recall if she performed neeted documentation and r Resident #1 to the ER for ly. se #3 on 12/30/22 at 9:59 the supervisor on duty on 22 when Nurse #1 and	F 684				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/24/2023 APPROVED . 0938-0391
STATEMENT OF DE AND PLAN OF COF	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345080	B. WING			( 01/0	C 04/2023
NAME OF PROVI	DER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE,	ZIP CODE		
			2	20 13TH AVENUE PLACE NW			
THE GREENS	AT VIEWMONT		H	HICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCEE	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
to t	the ER for evaluation as normally provided sident conditions for iff to shift report whi diological studies has sults; however, she owledge the studies build have been on the on the fax machine sults are received fr normalities are to be ovider, the copies plander located at the r -coming nurses to r nding x-ray results. In interview with Nurse A revealed she was pervisors/Unit Mana e one who obtained have radiological st ine on 11/22/22 and mpany to setup the mpleted. Nurse #4 i ceived orders, her n form the nurse assign sident's orders or ch wever, she could not 11/22/22 of the ord udies or the concern d she did not perfor esident #1 at the tim ray as a recommend they typically rece- em of abnormal results of they typically rece-	22 when he was transferred on. Nurse #3 indicated she d a generalized report on all the building during a brief ich would include when ad been ordered and the could not recall having any shad been ordered or she he lookout for the report to e. Nurse #3 stated when om the x-ray company, all e immediately called the laced in the provider's nurses' station and the eceive report of any se #4 on 12/30/22 at 12:15 one of the day shift ager in the facility and was the orders for Resident #1 udies of the left hip and d called the local x-ray appointment to have them indicated when she ormal process was to gned to the unit of the hanges in condition; ot recall who she informed ers for the radiological is with changes in therapy m a physical assessment of e, but strictly requested the dation of therapy staff.	F 684				

Facility ID: 923004

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 01/24/2023 1 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		345080	B. WING		_	( 01/(	; 04/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE GRE	ENS AT VIEWMONT			20 13TH AVENUE PLACE HCKORY, NC 28601	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	after the x-ray was ob not contacted the x-ra the result following the 11/22/22. An interview with Nur PM revealed she had during his stay; howe dates. Nurse #5 indic notified by a member complained of pain du some slight swelling in #5 stated therapy had and offloaded his LE's Manager about the x- unable to locate them According to Nurse #8 Manager that the resu she thought she gave stated if it was not list have been waiting for medication at the time Nurse #5 explained si or injuries which woul changes to Resident could not have been a without staff assistand A telephone interview at 12:45 PM revealed Resident #1; however x-ray being ordered s when the x-ray was o knowledge of what tim time looked for a resu	e typical range of 24 hours trained. She stated she had ay company herself to verify e order being made on se #5 on 12/30/22 at 12:00 worked with Resident #1 ver, could not verify which ated she recalled being of therapy that he had uring his treatment and had in his lower extremity. Nurse I placed him back in bed is and she asked the Unit ray results since she was in his medical record. 5, she was told by the Unit ults were still pending, and him pain medication but ed on the MAR she may an order for additional e if none was ordered. he was unaware of any falls d have resulted in the acute #1 and verified Resident #1 able to mobilize himself be had he fallen. with Nurse #6 on 12/30/22 she was familiar of r, she could not recall the tating in spite being on duty btained, she had no ne it was obtained and at no ilt or performed a physical secondary to his pain or	F 684				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 01/24/2023 APPROVED 0: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345080	B. WING		_	( 01/0	; 04/2023
NAME OF PI	ROVIDER OR SUPPLIER		- <b>·</b> [	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	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	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page Attempts to interview Attempts to interview unsuccessful. An interview with the on 1/4/22 at 10:30 AM aware of Resident #1 left hip fracture when 11/28/22 and was not to the hospital. The D x-ray company and be correcting concerns w following radiological indicated the facility d meeting of the interdis or 11/25/22 and there aware the results wer following the x-ray be indicated she was una that occurred in the far resulted in the fracture prior to admission and previous hospital stay explained typically all obtained within 24 ho performed but could r	e 31 PTA #2 were unsuccessful. Nurse #7 were Director of Nursing (DON) A revealed she had become 's x-ray which resulted in a she arrived to the facility on ified he had been admitted ON stated she called the egan formulating a plan for vith notification of results studies. She further id not hold their normal sciplinary team on 11/24/22 fore she was not made e not obtained on 11/23/22 ing performed. The DON aware of any fall or injury scility which would have e and believed it occurred d was undetected during his		I		TE	DATE
	no formal assessmen of pain or potential LE performed as these w	t of the ongoing complaints shortening had been rould be expected to be al record with any acute					
	change in condition.	an ooora with any douto					
	The Administrator was jeopardy via telephon	s notified of immediate e on 12/30/22 at 5:20 PM.					
	F684						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345080	B. WING				C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	ENS AT VIEWMONT				20 13TH AVENUE PLACE NW		
				F	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)	ЗE	(X5) COMPLETION DATE
F 684	Continued From page	32	F	684			
		ents who have suffered, or serious adverse outcome as npliance					
	provide a comprehent significant change in o	intervention and treatment					
	shortening of the leg of therapy that was repor- NP that was not addre- resident on 11/22/22 An X-Ray was ordered sent electronically on failed to fax due to ha and made one attempt answer at the facility a additional attempts. If results until 11/28/22 discovered to be a dis neck femur and reside	ddition, there was pain and of Resident #1 noted during orted to nursing staff and the essed by assessing the when X Ray was ordered. d on 11/22/22 with results 11/23/22. X Ray provider wing incorrect fax number of to call but did not get an and did not make any Facility failed to access at which time it was splaced subcapital fracture ent was sent to ED.					
	noted at risk for this d identified, and a self-i related to the monitor was initiated on 11/28 11/30/2022. The facil relates to the monitor	ith X Ray services were leficient practice, which was mposed plan of correction ing and completion of x-rays 3/2022 and completed on lity retains compliance as it ing of x-rays. seessed for undocumented, which changes in condition that					
	would result in a char	nge in the resident plan of an notification, thorough					

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PRINTED: 01/24/2023

	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	TE SURVEY MPLETED
		345080	B. WING			0	C 1/04/2023
NAME OF PI	ROVIDER OR SUPPLIER				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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 684	Managers or designer No other residents we o Specify the action the process or system fait adverse outcome from when the action will b On 11/28/22 an audit last 14 days was come found. On 11/28/22 education on reporting of all ord immediately to DON of On 11/28/22 DON rec Ray provider in relation acute X Ray findings number and creation DON contact informate facility to assure notified On 11/28/22 and ongoing reported to the DON of and will be followed un received. X Rays will a whiteboard each mo- meeting as well as the documented on Audit received.	ical intervention by Unit e on 12/30/22 - 12/31/22. ere identified. The entity will take to alter the lure to prevent a serious in occurring or recurring, and e complete of all X Rays ordered in the upleted. No concerns were in was provided to all Nurses ered X Ray results or designee. upuested a POC from the X on to no verbal notification of as well as correction of fax of a pop-up screen with tion when no answer at the ication. oing all X Rays will be or Designee when ordered p daily until results are be listed and monitored on orning during morning e Nurse Manager office and form until the results are	F	684	4		
	Regional Clinical Dire was specifically relate (specifically related to	ted on 11/28/22 by the ector. Education provided ed to change of condition o pain) and the new process agnostics tracking log to					

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PRINTED: 01/24/2023

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/24/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION	_	(X3) DATE	
		345080	B. WING				C 04/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
THE GREE	ENS AT VIEWMONT			220 13TH AVENUE PLAC	ENW		
				HICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page ensure compliance ar and Unit Managers we on 11/28/22. Educati related to change of or to pain) and the new p diagnostics tracking lo and effectiveness. On 12/30/22 - 12/31/2 educated to include T ADON, Unit Managers immediately report ch (specifically related to appearance of the hur change in behavior, A activities, therapy or c licensed nurses. This indications as well as including grimacing, w changes, etc for those able to verbalize a chas but not limited to incre educated on the expe completing assessme in condition and/or pa All licensed nurses wo Practitioner were educ assessment related to pain; and reporting to Extender (Nurse Prac 12/30/22 - 12/31/22 b Manager or designee, members who were n staff will receive traini information prior to re	<ul> <li>34</li> <li>ad effectiveness. The ADON ere educated by the DON on provided was specifically ondition (specifically related process of tracking pending og to ensure compliance</li> <li>22 all direct care staff were herapy staff by the DON, sor designee to anges in condition pain, including change in man anatomy) including a DL, or participation in ther usual patterns to education including verbal non-verbal indications withdrawing, mental status e residents who may not be ange in condition including eased pain. NP was ctation and importance of nt when notified of change in.</li> <li>orking and the Nurse cated on thorough o change in condition and/or Physician or Physician titioner) immediately on y DON, ADON, Unit</li> <li>All other licensed staff ot present, including agency ng to include the above turning to work. The</li> </ul>	F 68				
	director of nursing and responsible to ensure						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	2: 01/24/2023 1 APPROVED 2: 0938-0391
STATEMENT ( AND PLAN OF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		345080	B. WING					C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
THE GREI	ENS AT VIEWMONT				20 13TH AVENUE PLACE NV IICKORY, NC 28601	V		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	35	F	684				
	Alleged IJ removal da	te is 1/1/23.						
	with a validation comp staff interview and in- Staff were able to ver facility for ordering x-r radiological study res provider with results in to demonstrate the pr the electronic medica abnormal results were the mobile x-ray comp report and call the fac Additionally, staff wer understanding of the assessment to recogn	requirements for a physical nize acute changes in t as well as the urgency to						

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