STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Viewmont	220 13th Avenue Place NW Hickory, NC 28601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff, Resident Representative, emergency responders, Nurse Practitioner (NP), Medical Director, hospital staff, Program of All-Inclusive Care for the Elderly (PACE) staff interviews, the facility failed to supervise a moderately cognitively impaired resident (Resident #1) who obtained a cigarette lighter and ignited herself and her bedding on fire. On 4/09/26 at 4:39 PM the fire alarm at the facility sounded. Staff responded to Resident #1's room and noted smoke coming from under the closed door. When Nurse #1 opened the door, he found Resident #1 in flames on the top portion of her body. Nurse #1 and Nurse #2 grabbed bedding from the foot of the bed and began patting out the flames. Other staff responded to the room and began wetting washcloths and towels to fully extinguish the existing embers that were on Resident #1 and her bedding. Emergency Medical Services (EMS) arrived on scene and transported Resident #1 to a helicopter pad where she was flown to a trauma center. Resident #1 remained in the Burn Intensive Care Unit (ICU) at the time of the survey with second degree (damage to the top two layers of skin resulting in intense pain, swelling, blisters, and a wet, red appearance) and third degree (destroyed all skin layers, often damaging underlying fat, muscle, or bone, affected skin appears leathery, dry, and white, charred, or brown with little to no pain due to destroyed nerves) burns over 16% of her total body surface area (considered a major burn which required immediate emergency care). On 4/10/2026 Resident #1 had a nasogastric tube (NG) (flexible, temporary tube passed through the nose, esophagus and into the stomach for feeding) inserted to receive nutrition due to low intake by mouth. On 4/11/26 Resident #1 underwent excision (surgical removal of dead or dying tissue with no blood supply) of burned skin and application of allograft (transplantation of cells and tissues or organs from a donor a recipient) to abdomen and bilateral lower extremities and the hospital records indicated Resident #1 would have another surgery scheduled for skin grafting in approximately one week. The NG tube was discontinued on 4/16/25. The facility was a non-smoking facility but allowed staff members to smoke at the back of the facility. There was also a high likelihood for serious injury or harm to Resident #1's roommate, Resident #2, who was in the same room and had an oxygen concentrator that was not in use at the time. The deficient practice affected 1 of 3 residents reviewed for accidents (Resident #1). The findings included: Review of the Facility's Skilled Nursing Center Resident admission Agreement dated 11/15/2021 revealed:Section V. Rights and Responsibilities of Resident: C. 5. Tobacco-Free Environment Policy. The Center is committed to providing a healthy and safe environment for our employees, residents and all others. This facility is smoke free campus. Resident #1 was admitted to the facility on [DATE] with diagnoses that included epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity in the brain), chronic kidney disease, hemiplegia (severe or complete paralysis on one side of the body) and hemiparesis (mild or moderate weakness on one side of the body) following cerebral infarction (or a ischemic stroke- occurs when blood flow to the brain is blocked, starving brain tissue of oxygen and causing cell death) affecting left non-dominant side, major depressive disorder, anxiety disorder, and amputation of left lower extremity above the knee. Resident #1's (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physicians' orders revealed an order dated 2/19/2025 for PACE (PACE is a Medicare/Medicaid program that coordinates comprehensive care and services to supplement or manage a resident's care) every 2nd and 4th Tuesday of the month. A telephone interview was conducted on 4/15/2026 at 9:58 AM with the Community Support Liaison for PACE; he stated he was familiar with Resident #1. The Community Support Liaison stated Resident #1 used to come weekly on Tuesdays, but Resident #1 called out frequently. The Community Support Liaison revealed Resident #1 had refused to come to PACE twice in March when the driver arrived to pick her up. The Community Support Liaison verified the last time Resident #1 was transferred to PACE was 3/24/2026. The Community Support Liaison stated PACE was a non-smoking facility. The Community Support Liaison spoke with staff at PACE who stated they had not heard Resident #1 voice a desire to smoke or obtain smoking materials.A telephone interview was conducted on 4/15/2026 at 10:00 AM with the Social Worker for PACE; she stated she was familiar with Resident #1. The Social Worker stated she had conducted mental status exams on Resident #1 and the results ranged from mild to moderate cognitive impairment in the past year. The Social Worker stated she would agree Resident #1 had moderate cognitive impairment but did have some days when her cognition was better than others. The Social Worker stated he had worked with Resident #1 since 2018 and Resident #1 was a heavy smoker when she lived at home, prior to admission to the facility. The Social Worker stated since Resident #1 was admitted to the facility she had not heard Resident #1 voice a desire to smoke. The Social Worker stated Resident #1 and her family were aware the facility was nonsmoking when she was admitted and wanted Resident #1 to quit smoking due to her health conditions. A telephone interview was conducted on 4/15/2026 at 3:18 PM with the PACE NP who was familiar with Resident #1. The PACE NP stated she suspected Resident #1 had some underlying vascular dementia based on her cardiac history but did not know if that was an official diagnosis in her record. The PACE NP agreed Resident #1 had moderate cognitive impairment and verified that it was documented in a progress note from June 2025. The PACE NP denied Resident #1 ever voiced a desire to smoke or wanting a cigarette. Review of a PACE Nurse Practitioner (NP) progress note dated 6/10/2025 revealed Resident #1 was alert, in no acute distress, had usual mental status, with a plan for Resident #1 for cognitive impairment (moderate): no hallucinations or rapid decline in cognition, continue monitoring progression of memory loss and provide supportive care as needed. Resident #1's annual Minimum Data Set (MDS) dated [DATE] indicated Resident #1 did not use tobacco. Record review revealed a smoking safety evaluation dated 2/27/2026 that indicated Resident #1 did not smoke. Resident #1's quarterly MDS dated [DATE] revealed Resident #1 was moderately cognitively impaired and indicated Resident #1 had not experienced pain during the 7-day look back period, had impaired range of motion to upper and lower extremities on one side, used a wheelchair for ambulation, required set up assistance for eating, required substantial to maximum assistance with oral hygiene, bathing and upper body dressing, was dependent on staff for toileting hygiene, lower body dressing, putting on and taking off footwear and personal hygiene. Resident #1 required substantial to maximum assistance to roll left and right in bed and was dependent on staff for all other bed mobility. Review of the care plan dated 3/2/2026 revealed Resident #1 was care planned for Activity of Daily Living (ADL) self-care performance deficit related to limited mobility, related to left above the knee amputation, and left hemiparesis with interventions that included Resident #1 required assist by 1 to 2 staff to turn and reposition in bed as necessary, assist by 1 to 2 staff for toileting. Resident #1 was care planned for problems with short term memory loss with interventions that included ask yes/no questions in order to determine the resident's needs, use the resident's preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Provide the resident with necessary cues- stop and return if agitated. An interview was conducted on 4/14/2026 at 4:36 PM with Nursing Aide (NA) #1 who stated she was familiar with Resident #1 and had worked 7:00AM to around 4:00 PM on 4/9/2026 and was assigned to Resident #1 but was not in the facility at the time of the fire. NA #1 stated she took care of Resident #1 and provided peri care and changed her with NA #2. NA #1 stated two people (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	provided peri care to Resident #1 and she would roll toward the staff and hold on to them while the other staff provided care. NA #1 stated she had a lighter that looked like the one found with Resident #1 and it was now missing. NA #1 stated she did not normally carry her lighter into the facility, that she went out to car to smoke and ignited her cigarette. NA #1 stated the shirt she wore on 4/9/2026 did have a hole in the pocket, and if she had accidentally taken her lighter into the facility it would have been in her pocket. NA #1 stated she had tried to push another lighter through the hole in her shirt pocket at home and it had to be forced through the hole to fit. A follow up interview was conducted on 4/15/2026 at 11:20 AM and NA #1 verified she last saw Resident #1 on 4/9/2026 around 3:30 PM when she and NA #2 provided peri care, and at that time everything appeared normal and no lighter was seen in Resident #1's possession. NA #1 denied Resident #1 ever voiced a desire to smoke or wanting a cigarette. An interview was conducted on 4/15/2026 at 11:20 AM with NA #2 who stated she was familiar with Resident #1 and worked with Resident #1 from 7:00 AM to 11:00 PM on 4/9/2026. NA #2 stated she provided peri care to Resident #1 with NA #1 on 4/9/2026 around 3:30 PM and verified Resident #1 required assistance to roll from side to side in bed for staff to provide care and at times Resident #1 would hold onto staff while care was provided. NA #2 stated she went to care for Resident #1's roommate around 4:05 PM on 4/9/2026 and on her way out of the room she straightened Residents #1's sheets, asked Resident #1 if she needed anything then exited the room and closed the door as requested by the roommate. NA #2 stated she did not see a lighter in Resident #1's possession. NA #2 went on break around 4:20 PM and was not present in the building when the fire alarm sounded. NA #2 denied Resident #1 ever voiced a desire to smoke or wanting a cigarette. Review of Resident #2's quarterly MDS dated [DATE] revealed Resident #2 was cognitively intact. An interview was conducted on 4/14/2026 at 9:36 AM with Resident #2. Resident #2 verified she was Resident #1's roommate and was in the room at the time of the fire on 4/9/2026. Resident #2 stated on 4/9/2026 the privacy curtain was pulled between her and Resident #1's bed so Resident #2 could not see Resident #1. Resident #2 stated in the afternoon she thought she heard something fall on Resident #1's side of the room. Resident #2 indicated she called out to Resident #1 and asked if she was ok and if she had fallen. Resident #1 did not respond so Resident #2 asked Resident #1 if she needed help, and there was still no response so Resident #2 thought everything must be ok. Resident #2 stated a few minutes later she smelled smoke, called out to Resident #1 and asked if she smelled smoke and was something burning. Resident #2 stated there was no response, so she pushed her call bell and started to call out for staff and about that time she heard the fire alarm, and staff came very quickly and began working with Resident #1. Resident #2 stated she never saw any smoke, she only smelled it. Resident #2 denied she had any injury or harm from the incident. Resident #2 further stated Resident #1 sometimes talked about smoking. An oxygen concentrator was observed on the right side of Resident #2's bed. The oxygen concentrator was not running, and Resident #2 was not wearing the nasal canula during the interview. Resident #2 verified she did not wear her oxygen at all times. Review of Resident #1's medical record revealed an eMAR (electronic Medication Administration) entry dated 4/9/2026 which was visible when display eMAR was selected and written by Nurse #2 that indicated: the fire alarm sounded and identified the location source of the alarm was Resident 1's room. Nurse #1 and Nurse #2 found Resident #1 with bed linens smoldering and padded them out with other bed linens. Wet washcloths were applied to torso. breasts, groin and left-hand burn injuries. Fire Department (FD) and EMS were notified, and a lighter was found on bed. When Resident #1 was asked how did you get that by other staff, Resident #1 responded I stole it. Blood Pressure 180/120 (normal range 90/60 to 140/90), heart rate 87, (normal range 60-100), oxygen saturation 95% (normal range 95%-100%), Resident #1 had active wheezing and albuterol inhaler was given per MAR orders. Nurse #2 stayed with EMS until Resident #1 was transported via stretcher out of facility. An interview was conducted on 4/14/2026 at 2:53 PM with Nurse #2 who stated she was familiar with Resident #1 and was assigned to Resident #1's hall on 4/9/2026. Nurse #2 stated she was on 400-hall for medication pass. Nurse #2 stated when the fire alarm sounded, she started closing doors on 400 hall and saw (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse #1 coming down 400-hall talking on the phone and indicated the alarm was from Resident #1's room. Nurse #2 stated she followed Nurse #1 into Resident #1's room and saw smoke and little flames coming from Resident #1's bed linens. Nurse #2 stated they used the blanket from the foot of the bed to put out the flames, but orange embers remained on the linens so wet towels were placed on Resident #1. Nurse #2 stated Resident #1 never yelled or called out but appeared to be in shock or scared by the way Resident #1 just looked on while staff provided care. Nurse #2 assessed Resident #1 as Unit Manager #1 and Medication Aide (MA) #1 continued to apply wet towels. Nurse #2 obtained vitals on Resident #1 while Unit Manager #1 and MA #1 began to change and remove the burned linens and clothing from Resident #1's bed. Nurse #2 heard staff ask Resident #1 where did you get that lighter and saw a pinkish purple item from the corner of her eye, and Resident #1 responded she stole the lighter. Nurse #2 assessed Resident #1 and noted discoloration to the right breast, redness near her groin area and red area on left hand with black wounds. Nurse #2 stated Resident #2 started wheezing so she administered Resident #1's inhaler per orders then FD and EMS arrived and took over care for Resident #1. Nurse #2 stated she had worked with Resident #1 for about 2 years and had never heard her complain of pain. Nurse #2 stated normally Resident #1 was alert to person and place, but Nurse #2 believed Resident #1 did have some dementia. Nurse #2 denied Resident #1 ever voiced a desire to smoke or wanting a cigarette. Nurse #2 stated Resident #2 had an oxygen concentrator but did not use it all the time. Nurse #2 stated on 4/9/2026 Resident #2 was not wearing her oxygen, and the concentrator was turned off. Review of the electronic Medication Administration Record (eMAR) for April 2026 revealed Resident #1 received ProAir HFA Inhalation Aerosol Solution 108 (90 Base) mcg/Albuterol Sulfate 2 puffs on 4/9/2026 at 4:50 PM administered by Nurse #2. Resident #1's physicians' orders revealed an order dated 1/17/2025 for ProAir Inhalation Aerosol Solution /Albuterol Sulfate (an inhaled medication that relaxes the airway muscles, improving airflow in the lungs) 2 puffs inhale orally every 6 hours as needed for wheezing.An interview was conducted on 4/14/2026 at 12:48 AM with Nurse #1, he stated he was familiar with Resident #1 and was working at the facility on 4/9/2026. Nurse #1 indicated on 4/9/2026 he was in the medication room when the fire alarm sounded at 4:39 PM. Nurse #1 looked at the fire panel and saw the location of the alarm was Resident #1's room. Nurse #1 called the Maintenance Director at 4:40 PM to notify him the fire alarm had gone off, as he made his way to Resident #1's room Nurse #1 noted the call light was on and there was light colored smoke starting to come out from under the door into the hallway. Nurse #1 opened the door to Resident #1's room and saw flames and smoke on Resident #1's abdomen and upper torso area. Nurse #1 stated Nurse #2 entered Resident #1's room right after him. Nurse #1 stated Resident #1 looked at Nurse #1 with a surprised look when he entered the room and was not voicing any pain. Nurse #1 stated he grabbed the blanket at the foot of Resident #1's bed and began to pat out the flames on Resident #1. Nurse #1 stated when the fire was extinguished, he saw burns to Resident #1's breast and abdomen and instructed the other staff in the room to put cold compresses on Resident #1. Nurse #1 stated he told the Maintenance Director there was a fire in Resident #1's room then called 911 at 4:41 PM, and at the same time the alarm company called the facility due to the fire alarm notification they received. 911 and the alarm company were informed of the fire and that they needed to come to the facility right away. Nurse #1 left Nurse #2, the Unit Manager #1 and MA #1 with Resident #1 and went to prepare paperwork for Resident #1's transfer and made sure EMS had a clear path to Resident #1's room. Nurse #1 stated when Resident #1 was first admitted to the facility, she talked about smoking, but that had been a few years ago.An interview was conducted on 4/14/2026 at 12:26 PM with Unit Manager #1 and she stated she was familiar with Resident #1 and worked at the facility on 4/9/2026. Unit Manager #1 stated she was on 300-hall when she heard the fire alarm she went to grab the fire extinguisher, someone at the panel said it was in Resident #1's room, and she went to Resident #1's room and entered behind MA #1 and saw a few embers and smoke around Resident #1. Unit Manager #1 stated she and MA #1 got cool cloths and placed them on Resident #1, then changed Resident #1's brief and sheets to make sure there was no further embers (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	or burns. Unit Manager #1 stated Resident #1 did not appear to have any difficulty breathing while the sheets were changed and answered MA #1 and stated she stole the lighter but did not say who she stole it from. Unit Manager #1 asked Resident #1 how she was doing while Nurse #2 took vitals and Resident #1 responded she did know what we were talking about. Unit Manager #1 stated Resident #1 started to wheeze after this, and Nurse #2 administered an inhaler. Unit Manager #1 stated when FD and EMS arrived and took over care, she called and notified Resident #1's family. Unit Manager #1 denied Resident #1 ever voiced a desire to smoke or wanting a cigarette. An interview was conducted on 4/14/2026 at 11:33 AM with Medication Aide (MA) #1, and MA #1 stated she was familiar with Resident #1 and was working on 4/9/2026 when the fire occurred. MA #1 stated she was about to start the medication pass on another hall when the fire alarm sounded around 4:40 PM. MA #1 stated she closed her medication cart, grabbed the fire extinguisher, looked at the fire panel which indicated Resident #1's room as the location that triggered the alarm, and she headed to Resident #1's room. MA #1 arrived at Resident #1's room and Nurse #1 and Nurse #2 were already in the room with Resident #1. MA #1 observed orange embers on Resident #1's shirt and sheets. MA #1 stated the remaining part of Resident #1's shirt was removed from Resident #1's breast, abdomen and left hand and burns were also noted on Resident #1's inner thighs. The blankets were removed from Resident #1's bed and placed on the floor. MA #1 stated Unit Manager #1 arrived and began to wet down towels and place them on Resident #1's skin from neck to mid-thigh. MA #1 stated Resident #1's skin appeared melted and appeared to be turned/rolled out to the side and the skin appeared burned and black, the other skin was very pink. MA #1 stated Resident #1 was alert, answered questions and did not appear to have difficulty breathing. MA #1 stated she and Unit Manager #1 began to clean Resident #1 in order to remove all the sheets on the bed and make sure there were no remaining embers. MA #1 stated as Resident #1 was rolled toward her, toward the right side of the bed, Resident #1 was attempting to reach for the nightstand located at the head of the bed on the right side. MA #1 looked toward the direction Resident #1 was reaching and saw the lighter on the nightstand and asked Resident #1 how she got the lighter, and Resident #1 responded she stole it. MA #1 asked Resident #1 who she stole it from, and Resident #1 stated she didn't know who she stole it from. MA #1 removed the lighter from the nightstand, and it was given to Nurse #1 for security and safety. MA #1 stated Resident #1 did not voice any pain and appeared calm. MA #1 stated emergency responders arrived very fast, within 5 minutes, and fire fighters arrived first. MA #1 stated EMS removed the wet towels from Resident #1 to get dimensions of the burns. MA #1 stated she did not know who the lighter that was found belonged to. MA #1 stated Resident #1 was not able to use the left side of her body due to the stroke, but she could feed herself with her right hand. MA #1 stated she had seen Resident #1 open a bottle of soda, and thought Resident #1 could strike a lighter. MA #1 denied Resident #1 ever voiced a desire to smoke or wanting a cigarette. A telephone interview was conducted on 4/14/2026 at 1:58 PM with NA #3 and she stated she was familiar with Resident #1 and worked 3:00 PM to 11:00 PM on 4/9/2026 on Resident #1's hall but was not assigned to Resident #1. NA #3 stated she was letting a family out of the facility when the fire alarm went off, and then saw nurses rush to Resident #1's room. NA #3 followed them to the room and heard someone say Resident #1 had caught fire. NA #3 asked what to do and helped wet towels that other staff placed on Resident #1. NA #3 did not see the burns but stated Resident #1 just looked around, she did not scream and did not appear to be in pain. NA #3 stated the lighter was removed from the nightstand. NA #3 denied Resident #1 ever voiced a desire to smoke or wanting a cigarette. Review of a Situation Background Assessment Recommendation (SBAR) communication form dated 4/9/2026 and written by Unit Manager #1 revealed Resident #1 was burned from upper chest to bilateral inner thighs red/orange embers were still on sheet, which was smoldered and removed, then cool cloths placed over upper torso to bilateral thighs. Resident #1 was alert and talking, 911 was called, Resident #1 had the following documented vital signs: a blood pressure of 180/120, pulse of 46, respirations of 22, and indicated Resident #1 did not have pain. A telephone interview was conducted on 4/14/2026 at 3:08 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	from 4/9/2026 to 4/17/2026 revealed Resident #1 arrived at the Emergency Department (ED) on 4/9/2026 and indicated critical care was required for condition of burn activation (indicated a medical emergency often requiring immediate specialized critical care due to the extensive destruction of all skin layers, nerves, and sometimes underlying tissue. Critical care activation is generally for burns less than 20% of the TBSA in adults), full thickness (destroy both skin layers) burns to abdomen. Intervention was immediately required due to the risk of substantial deterioration, including death and infection. ED physician note revealed Resident #1 had suffered 16% total body surface area burns throughout the abdomen, suprapubic region, inguinal region, right foot and left hand, full thickness burns throughout the abdomen, partial thickness along the right arm, and indicated Resident #1 denied pain. Resident #1's airway was intact, no soot in mouth, no singed nasal hairs seen. Initial plan to admit Resident #1 to burn unit, and Resident #1 did not require significant pain medication in the ED. Progress noted indicated Resident #1 would require significant debridement which would be completed in the burn ICU. Resident #1 was admitted to the burn ICU from the ED with the following diagnoses: 3rd degree burn of abdominal wall with loss, full thickness burn of left breast, burn of right thigh second degree, partial thickness (damage the top layer of skin and part of the second layer) burn of multiple digits of left hand including partial thickness burn of thumb, burn erythema (a persistent, net-like red or brown rash caused by chronic, low-level heat exposure) of right foot. Further review of hospital records revealed Resident #1 had low intake by mouth and had a nasogastric tube (NG) (flexible, temporary tube passed through the nose, esophagus and into the stomach for feeding) placed on 4/10/2026 to receive nutrition. Review of surgical notes from 4/11/2026 revealed Resident #1 underwent excision (surgical removal of dead or dying tissue with no blood supply) of burned skin and application of allograft (transplantation of cells and tissues or organs from a donor a recipient) to abdomen and bilateral lower extremities. Plan to return to the operating room in approximately 1 week to remove the allograft and place autograft (a surgical procedure where tissue such as skin, is transplanted from one part of a patient's body to another, using their own living cells). Review of hospital progress notes revealed the NG tube was discontinued on 4/16/2026 and Resident #1 was placed on a dysphagia diet (modified food and fluid textures to make swallowing safer and easier while ensuring adequate nutrition) and tolerated it well. Attempted to contact Resident #1 by phone on 4/14/2026 at 4:13 PM, 4/15/2026 at 9:05 AM, and 1:40 PM, and 4:28 PM in Resident #1's hospital room, but Resident #1 did not answer the phone. A telephone interview was conducted on 4/15/2026 at 10:19 AM with the Hospital Charge Nurse for the unit Resident #1 was currently assigned. Hospital Charge Nurse stated Resident #1 was currently in the burn unit ICU and was stable. The Hospital Charge Nurse reported Resident #1 had surgery on 4/11/2026 for excision of burned areas and had scattered 2nd and 3rd degree burns on 16% of her body. He stated the burns currently had a burn dressing and Resident #1 would have another surgery for definitive grafting. The Hospital Charge Nurse stated he was told Resident #1 had dementia and had been alert to self and time. The Hospital Charge Nurse indicated Resident #1 had not reported pain. A telephone interview was conducted on 4/15/2026 at 3:20 PM with the Hospital Social Worker who was familiar with Resident #1. The Hospital Social Worker stated she had spoken to Resident #1 that morning and Resident #1 was disoriented to place, had a Total Body Surface Area (TBSA) burn of 16%, 9% second degree burns and 7% third degree burns, which were on the Resident's chest, abdomen bilateral back of thighs, left radius and hand. The Hospital Social Worker stated when she asked Resident #1 what happened Resident #1 stated a staff member went to hug her and a lighter fell out of the staff's scrubs and Resident #1 grabbed it and the staff did not know. Resident #1 stated she became curious and played with the lighter then the fire started. The Hospital Social worker verified Resident #1 had surgery on 4/11/2026 for excision of burned areas and a skin substitute was applied that was temporary to try to get the skin to heal, but Resident #1 would have another surgery upcoming for more permanent grafting. A telephone interview was conducted on 4/15/2026 with Resident #1's Resident Representative (RR). The RR stated he had visited Resident #1 at the hospital on 4/14/2026 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Viewmont	220 13th Avenue Place NW Hickory, NC 28601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and Resident #1 stated someone dropped the lighter in her room and Resident #1 picked it up without anyone seeing it, then she