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	05/01/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on observations, record review, and staff interviews, the facility failed to accurately code a Minimum Data Set assessment when they failed to include a resident's diagnosis of neurogenic bladder for 1 of 1 resident reviewed for catheters. (Resident #74) The findings included: Resident #74 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of prostate, aftercare following joint replacement surgery, and neuromuscular dysfunction of bladder. Review of Resident #74's quarterly Minimum Data Set assessment dated [DATE] revealed Resident #74 was coded as having a catheter. Additionally, under section I, Resident #74 was not coded as having neurogenic bladder. Review of Resident #74's physician orders revealed the following order in part dated 01/07/25: Insert urethral indwelling urinary catheter due to neurogenic bladder. An interview with MDS Nurse #1 on 05/01/25 at 10:53 AM revealed information for diagnoses included in a Minimum Data Set assessment is typically retrieved from multiple sources that included nurse practitioner notes and hospital discharge summaries. She indicated she does not typically review physician orders in the system as the program should pull those diagnoses over into the Minimum Data Set assessment automatically. She reported she did not know what happened with Resident #74's quarterly Minimum Data Set assessment and reported he did have a diagnosis of neurogenic bladder and that it should have been accurately reflected in the quarterly Minimum Data Set assessment dated [DATE]. An interview with the Director of Nursing on 05/01/25 at 11:09 AM revealed she believed diagnosis information for Minimum Data Set assessments is pulled from multiple areas including diagnosis lists, physician orders, discharge summaries, and physician notes. She stated that with Resident #74's catheter order indicating that it was used for neurogenic bladder, that the diagnosis should have been recorded in Resident #74's quarterly Minimum Data Set assessment dated [DATE]. The Director of Nursing also indicated she expected Minimum Data Set assessments to be accurate and reflect the individual resident and their care needs. An interview with the Administrator on 05/01/25 at 11:18 AM revealed she expected Minimum Data Set assessments to be accurate and reflect the individual resident and their care needs.

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.

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

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	05/01/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on observations, record reviews, staff and resident interviews, the facility failed to ensure Resident #35 swallowed medication during medication administration for 1 of 2 residents reviewed for professional standards. The findings included: Resident #35 was admitted to the facility on [DATE] with diagnoses that included coronary artery disease, diabetes mellitus, peripheral vascular disease and Alzheimer's disease. Resident #35's quarterly Minimum Data Set assessment dated [DATE] revealed the Resident was cognitively intact. Resident #35's medical record revealed physician orders for *clopidogrel bisulfate 75 milligrams (mg) by mouth in the morning for peripheral vascular disease dated 02/05/25, acetaminophen 325 mg 2 tablets by mouth twice a day for pain dated 02/26/25, famotidine 20 mg by mouth twice a day for reflux dated 11/13/24, gabapentin 300 mg by mouth twice a day for neuropathy dated 02/17/25 and dapagliflozin propanediol 10 mg by mouth once a day for diabetes mellitus dated 11/14/24. On 04/29/25 at 8:37 AM an observation and interview were made of Resident #35 while she was lying in her bed eating breakfast. On the Resident's over bed table was a medicine cup that contained 6 pills. Resident #35 explained that it was her morning medication that some nurses leave with her and some do not. Resident #35 stated Nurse #1 gave her the medications that morning and placed them on the table. The Resident indicated she would take the medications when she was ready. On 04/29/25 at 8:47 AM an interview was conducted with Nurse #1 who explained that Resident #35 was with it so she thought it would be okay to leave her medications with her to take. The Nurse stated 04/29/25 was the first time she left Resident #35's medications at her bedside for her to take on her own. On 04/30/25 at 11:40 AM an interview was conducted with the Director of Nursing (DON). The DON explained that Resident #35 had not been assessed to be able to self-administer her medications and Nurse #1 should not have left the medications at her bedside. The DON indicated the nurses were educated to ensure the residents swallowed their medications and not leave them at their bedside.

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	05/01/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on observations, record reviews, manufacturer's instructions, and staff and Pharmacy Consultant interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 26 opportunities, resulting in a medication error rate of 11.54% for 1 of 4 residents observed during the medication administration (Resident #17 and Resident #46). The findings included: 1. Resident #17 was admitted to the facility on [DATE] with diagnoses that included renal insufficiency, dyspnea, shortness of breath and vascular dementia. Resident #17's medical record revealed orders for *fluticasone-salmeterol (a corticosteroid) 100-50 MCG/ACT (microgram per actuation) one inhalation orally twice a day for shortness of breath. Rinse mouth after use dated 12/08/23 and *artificial tears 1% instill two drops in both eyes twice a day for dry eyes dated 04/03/24. The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #17 was cognitively intact. On 04/29/25 at 8:59 AM an observation of a medication pass was made of Nurse #1 who was medicating Resident #17. Nurse #1 handed the Resident the inhaler and allowed the Resident to administer one puff and inhale the medication. Resident #17 did not rinse her mouth out nor did Nurse #1 instruct Resident #17 to rinse her mouth. Nurse #1 then attempted to instill the Resident's eye drops when Resident #17 stated she could do it herself and the Nurse handed the eye drops to the Resident. Resident #17 closed her eyes then drug the tip of the eye drop bottle over her left eye lashes then over her right eye lashes and again over her left eye lashes then stated, that eye is worse. An interview was conducted with Nurse #1 at 9:16 AM on 04/29/25. The Nurse was asked what she thought about the medication pass to Resident #17 and the Nurse explained that the Resident did not instill the eye drops correctly because Resident #17 rubbed the tip of the bottle on her eye lashes and if she had an infection going on, bacteria could potentially be on the eye drop bottle now. The Nurse stated she would get a new bottle of eye drops for Resident #17. Nurse #1 stated that the Resident put more than two drops in each eye. When the Nurse was asked what she thought about the inhaler, Nurse #1 stated the Resident did not rinse her mouth out after she administered the inhaler to herself, nor did she instruct Resident #17 to rinse her mouth out. When asked why she did not instruct the Resident to rinse her mouth out the Nurse stated she was nervous. On 04/30/25 at 11:40 AM an interview was conducted with the Director of Nursing (DON). The DON explained that Resident #17 had not been assessed to be able to self-administer her medications and Nurse #1 should not have allowed the Resident to do so. The DON stated she felt Nurse #1 would have administered the medications correctly if she had done it herself. (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	05/01/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Pharmacy Consultant on 04/30/25 at 2:10 PM who explained that the manufacturer's recommendation was for the residents to rinse their mouths after administering steroid inhalers because of the risk of thrush and some residents were at higher risk for thrush. The Pharmacy Consultant stated if the physician's order stated to rinse mouth after use, then it should be done. 2. The manufacturer's instructions for prefilled Lispro insulin pen indicated that priming the insulin pen each time was an important step to ensure there were no air bubbles in the insulin and the full dose of insulin was given. Priming the insulin pen: 1. Dial up 2 units: turn the dose selector dial to 2 units, 2. Prime the pen: Press the injection button to let out any air bubbles and ensure the insulin is flowing correctly, 3. Check for a drop of insulin: you should see a drop of insulin on the tip of the needle, 4. Repeat if necessary. Resident #46 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus. The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #46 was cognitively intact. Resident #46's medical record revealed a physician order dated 04/02/25 for Lispro insulin via pen injector, inject 8 units subcutaneously before meals on Monday, Wednesday and Friday. On 04/30/25 at 11:31 AM an observation was made of Nurse #2 preparing to administer insulin to Resident #46 via an insulin pen. The Nurse removed the Lispro insulin pen from the medication cart and set the counter to 8 units. Nurse #2 administered the 8 units of insulin without priming the insulin pen as advised by the manufacturer's instructions. An interview was conducted with Nurse #2 at 11:37 AM on 04/30/25. The Nurse was asked to explain the procedure when giving insulin using an insulin pen and Nurse #2 stated she gave the insulin by the five rights of giving any medication. When the Nurse was asked if she was aware of priming the insulin pen before giving the insulin the Nurse stated she thought that was only for when the insulin pen was used for the first time. An interview was conducted with the Director of Nursing (DON) on 04/30/25 at 11:41 AM. The DON explained that it was the facility's policy to prime insulin pens before you inject the insulin prescribed to the resident and Nurse #2 should have primmed the insulin pen. During an interview with the Pharmacy Consultant on 04/30/25 at 2:14 PM the Pharmacy Consultant explained priming the insulin pen is recommended because there could be air bubbles in the chamber of the pen but there were very small incidences of that, but it had to be recommended. She indicated to prime the insulin pen was usually recommended with new pens.

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	05/01/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37280 Based on observations, record reviews and interviews, the facility failed to follow their Handwashing/Hand Hygiene policy when the Wound Nurse performed a pressure ulcer treatment on Resident #51 and did not wash or sanitize her hands before donning new gloves. This practice occurred for 1 of 2 staff members (Wound Nurse) observed for infection control. The findings included: Review of the facility's policy entitled Handwashing/Hand Hygiene last revised in October 2015 read in part: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. 7. Use alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: m. After removing gloves. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves. On 04/29/25 at 10:45 AM an observation was made of the Wound Nurse performing wound care to Resident #51's stage IV sacral pressure ulcer. The Wound Nurse washed her hands and donned a gown, and gloves then set up a work surface in preparation for the wound care. The Wound Nurse removed the old dressing which had a moderate amount of drainage then removed her gloves and washed her hands before she applied new gloves. The Wound Nurse then cleansed the stage IV pressure ulcer and removed her gloves and without washing or sanitizing her hands she applied new gloves to continue the treatment by applying the medicated pad and border dressing to secure the wound. During an interview with the Wound Nurse on 04/29/25 at 10:55 AM the Wound Nurse was asked to review the steps of the wound care procedure. The Wound Nurse repeated the steps of the procedure and when she stated she removed her gloves after she cleansed the wound she stopped and stated, I did not wash my hands before I put on new gloves. The Wound Nurse added she usually did wash her hands after she removed her gloves, but she was nervous being watched. At 10:57 AM on 10/29/25 an interview was conducted with the Director of Nursing (DON). The DON explained it was the facility's policy to utilize hand washing or sanitizing when gloves were removed. She stated the Wound Nurse should have sanitized her hands before donning new gloves.