STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345232	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Hickory	3031 Tate Boulevard SE Hickory, NC 28602

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to provide a dignified dining experience when the Speech Therapist (ST) stood in the hallway beside a dependent resident while assisting him during a meal 1 of 8 residents reviewed for dignity (Resident #70). The reasonable person concept was applied to this deficiency as individuals might feel a lack of dignity when staff assisted them in the hallway and when standing over them. Findings included:Resident #70 was admitted to the facility 11/23/22 with diagnoses including malnutrition and feeding difficulty. The significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had severe cognitive impairment and required partial/moderate staff assistance with eating. A continuous observation of the lunch meal was conducted on 01/20/26 from 1:13 PM through 1:18 PM. Resident #70 was sitting in his wheelchair in the hall directly across from the nurse's station with his meal tray on an overbed table in front of him. Three empty chairs were observed behind the nurse's station. The Speech Therapist (ST) was observed standing on Resident #70's right side giving him bites of food. In an interview with the ST on 01/22/26 at 1:20 PM she confirmed she fed Resident #70 the lunch meal on 01/20/26 in the hallway and stood during the entire time she was assisting Resident #70. She stated she did not see any chairs available and that was why she did not sit while assisting Resident #70. The ST stated Resident #70 normally ate in the dining room but ate in the hallway on 01/20/26 due to the flu/COVID-19 outbreak. An interview with the Director of Nursing (DON) on 01/23/26 at 11:12 AM revealed she expected staff to be seated when feeding residents. She stated she felt feeding residents in the hallway was a safer option than in their rooms because more staff were available if an emergency occurred. An interview with the Administrator on 01/23/26 at 12:11 PM revealed he expected residents to be fed in a respectful manner and for staff to be seated when they fed residents.

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
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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, the facility failed to maintain a sanitary wheelchair and sanitary geriatric chairs for 3 of 4 residents reviewed for safe, clean, comfortable and homelike environment (Resident #70, Resident #13, and Resident #68). Findings included:A. An observation of Resident #70's wheelchair on 01/20/26 at 1:13 PM revealed dried yellow-brown substance to both arm rests, the frame, and all four wheels. Additional observations of Resident #70's wheelchair on 01/21/26 at 10:17 AM, 01/21/26 at 12:47 PM, and 01/23/26 at 9:50 AM revealed the wheelchair remained in the same condition with a dried yellow-brown substance to both arm rests, the frame, and all four wheels. B. An observation of Resident #13's geriatric chair on 01/20/26 at 12:23 PM revealed dried white and yellow substances to both arm rests, a dried yellow-brown substance on the padding to the left of the resident's head, and visible strands of hair or string-like debris wrapped around parts of all four wheels.Additional observations of Resident #13's geriatric chair on 01/21/26 at 10:25 AM and 01/23/26 at 8:32 AM revealed the geriatric chair remained in the same condition with dried white and yellow substances to both arm rests, a dried yellow-brown substance on the padding to the left of the resident's head, and visible strands of hair or string-like debris wrapped around parts of all four wheels.C. An observation of Resident #68's geriatric chair on 01/20/26 at 12:24 PM revealed a dried white substance to both arm rests and visible strands of hair or string-like debris wrapped around parts of all four wheels. Additional observations of Resident #68's geriatric chair on 01/21/26 at 10:27 AM, 01/22/26 at 12:44 PM, and 01/23/26 at 9:50 AM revealed the geriatric chair remained in the same condition with a dried white substance to both arm rests and visible strands of hair or string-like debris wrapped around parts of all four wheels. A joint interview was conducted with the Environmental Services Director and Administrator on 01/23/26 at 9:50 AM. The Environmental Services Director stated wheelchairs, and geriatric chairs were cleaned once a month and as needed by housekeeping staff, and they were last cleaned on 12/11/25. The Environmental Services Director further stated housekeeping staff were not notified by nursing staff that the wheelchair or geriatric chairs needed to be cleaned. The Administrator stated he expected wheelchairs and geriatric chairs to be clean, and he expected nursing staff to notify the housekeeping staff if chairs needed to be cleaned more frequently than once a month.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to complete thorough skin assessments to identify and obtain orders for the care of a reddened area on the right palm caused by the resident's middle fingernail extending 1/4 inch beyond the end of his finger and pressing into the palm of his hand for 1 of 3 residents reviewed for contracture care (Resident #24). The findings included:Resident #24 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, diabetes mellitus, contracture of left hand, contracture of right hand and dementia.A physician order dated 01/30/24 specified a head-to-toe skin assessment every Tuesday on 3:00 PM to 11:00 PM shift. Review of Resident #24's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired and required total assistance with all activities of daily living except eating for which he required partial to moderate assistance. The assessment also revealed he was at risk of developing pressure ulcers/injuries but at present had no unhealed pressure ulcers or injuries or open lesions.Review of a physician order dated 10/23/25 indicated to apply bilateral palm guards as tolerated - check skin integrity prior to applying. One time a day per therapy services and removed per schedule. Review of Resident #24's care plan dated 10/30/25 revealed a focus area for the resident having an activity of daily living (ADL) self-care performance deficit related to disease process, risk for decline in physical function, chronic obstructive pulmonary disease, respiratory failure, diabetes mellitus, dementia and bilateral hand contractures. The goal was for Resident #24 to have all needs anticipated and met by staff through the review date of 01/30/26. The interventions included:Adaptive equipment to help resident to feed self - universal cuff (an assistive device that helps residents with weak grip or limited dexterity hold objects like utensils, pens or toothbrushes, promoting independence in daily activities by securing the item in a pocket on the hand), dycem (a unique, grippy, antimicrobial polymer material available in mats or rolls used for non-slip stabilization) placemat and divided plate.The resident requires partial to moderate assist of one and divided plates with meals.Physical therapy (PT) and occupational therapy (OT) evaluation and treatment as per MD orders.The care plan also revealed a focus area for the resident having an alteration in musculoskeletal status related to contractures of bilateral hands. The goal was for Resident #24 to remain free of injuries or complications related to bilateral hand contractures through the review date of 01/30/26. The interventions included:Monitor/document/report as needed any signs or symptoms or complications related to arthritis, joint pain, joint stiffness, usually worse on wakening, swelling, decline in mobility, decline in self-care activity, contracture formation/joint shape changes, crepitus (creaking or clicking with joint movement), pain after exercise or weight-bearing.Adaptive equipment for eating, bilateral hand splints per orders. Provide good hygiene and monitor skin. Notify provider of any complications.Review of Resident #24's weekly skin assessment dated [DATE] and completed by Nurse #3 revealed his skin was dry, he had a pressure-reducing device on his bed, he had no edema and his fingernails were cleaned and trimmed.Review of Resident #24's daily skilled nursing notes dated 01/01/26 through 01/23/26 revealed a progress note on 01/15/26 written by MDS Coordinator #1 regarding the resident. MDS Coordinator #1 indicated the resident had contractures to bilateral hands and had special devices he used to feed himself and bilateral hand splints per orders as well. She indicated in her note that although Resident #24 was at risk for skin breakdown that he currently had none.A telephone interview on 01/26/26 at 2:16 PM with MDS Coordinator #1 revealed she had completed the assessment on Resident #24 on 01/15/26. She stated that she typically assessed the resident herself and reviewed the notes in his electronic medical record. MDS Coordinator (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 stated she had not taken the resident's splints off his hands and observed his hands for skin issues and stated that she typically did not take his splints off to observe his hands when he had them on. She further stated she was not aware of any skin issues on his hands.An observation of Resident #24 on 01/20/26 at 9:15 AM revealed him sitting up in his high-back wheelchair in his room dressed for the day. The resident's hands were noted bilaterally to be contracted with the right hand greater than the left hand. His fingernails on the left hand were noted to be long and extended 1/4 inch beyond the end of his fingers. On his right hand the thumb, middle, and pinkie fingernails were long and extended 1/4 inch beyond the end of his finger. The middle finger on the right hand was bent at the proximal digit to the palm of the hand causing the finger and nail to press into the palm and the fingernail had made an indention in the palm of the hand. Upon closer observation the middle finger had made a reddened area approximately 0.2 centimeters (cm) by 0.2 cm by 0.1 cm that appeared to have been open at one time but no longer open but red in color. The indention was a match to his nail on the middle finger. The fourth finger on his right hand was bent at the distal digit with the bottom of the finger pressed into the palm of the hand and the nail on the fourth finger was thick and uneven on the top of the nail. Resident #24 stated he would like for his fingernails to be trimmed and said he didn't like for them to be long because they dug into the skin of his hand.An observation on 01/21/26 at 9:13 AM revealed Resident #24 sitting in his high-back wheelchair in the hallway with other residents participating in activity with snacks and drinks. The resident's fingernails remained long and appeared the same as on 01/20/26. An observation on 01/21/26 at 3:35 PM revealed Resident #24 resting in bed with clothes on with his universal cuff still on his left hand from lunch. The right hand had no palm guard on and the resident's right palm had a malodor coming from his hand. The resident stated the left hand splint (universal cuff) allowed him to be able to feed himself using built up utensils and stated the staff put the utensil in the pocket for him in his left palm. He stated no one had been in and talked with him about cutting his fingernails.Review of Resident #24's weekly skin assessment dated [DATE] and completed by Nurse #1 revealed his skin was dry and cool, he had a pressure-reducing mattress with no edema present and no new skin abnormalities noted. The document also revealed his fingernails were cleaned and trimmed.A telephone interview on 01/22/26 at 12:09 PM with Nurse #1 revealed she had completed Resident #24's skin assessment on 01/21/26. She stated she had not noticed any area on the palm of his right hand or that his nails were long and said maybe she should have used a flashlight so she could see his skin better when completing her assessment. Nurse #1 further stated she had noticed a malodor in his right hand before and had removed and cleaned moist exudate from the palm and put powder on his palm after cleaning it.An observation of Resident #24 and interview on 01/22/26 at 10:03 AM with Nurse #3 revealed the resident was not wearing his palm guards and when Nurse #3 saw the resident's fingernails he agreed his fingernails needed to be trimmed, and he stated he was not aware of the red area on the resident's palm caused by his fingernail. Upon closer observation the middle finger had made a reddened area approximately 0.2 cm by 0.2 cm by 0.1 cm that appeared to have been open at one time but no longer open but red in color. The indention in his palm was a match to his nail on the middle finger. An interview on 01/22/26 at 9:52 AM with Nurse Aide (NA) #1 revealed that she cared for Resident #24 frequently on 1st shift (7:00 AM to 3:00 PM). NA #1 stated she was caring for Resident #24 on 01/22/26 and that he had adaptive equipment that he used and a special splint that he used on his left hand that allowed him to feed himself. She stated they sometimes assisted him with his meals but said he liked to use his splint to feed himself. NA #1 further stated that Resident #24 usually got his showers on 2nd shift (3:00 PM to 11:00 PM) and said that was usually when staff trimmed his fingernails after his shower but (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she didn't know the last time they were trimmed and filed. She further stated he was dependent for his care and said she had occasionally noted a foul odor coming from his right hand and had cleaned it good and dried it so there was no moist exudate in the hand. NA #1 walked into Resident #24's room and observed his fingernails and the reddened area on his right palm caused by his middle fingernail pressing into his palm and said his fingernails needed to be trimmed. NA #1 stated she had not noticed the area on his palm before 01/22/26. She further stated she would let the nurse know Resident #24's fingernails needed to be trimmed since he was diabetic, and she could not trim them.An observation of Resident #24 and interview on 01/22/26 at 10:23 AM with the Director of Nursing (DON) revealed the resident's middle finger on the right hand was bent at the proximal digit to the palm of the hand causing the finger and nail to press into the palm and the fingernail had made an indention in the palm of the hand. Upon closer observation the middle finger had made a reddened area approximately 0.2 centimeters (cm) by 0.2 cm by 0.1 cm that appeared to have been open at one time but no longer open but was red in color. The indention was a match to his nail on the middle finger. The DON stated the reddened area on his right palm from his middle fingernail pressing into his palm should not have happened and said that his fingernails needed to be trimmed and filed. The DON further stated the nurses should be checking his hands and palms daily and especially during their weekly skin assessments and should be removing the palm guards to thoroughly observe his skin. She stated it should have been recognized and reported to the Wound Nurse for treatment. The DON indicated she would get OT to see him to see what type of palm guards they could get him to prevent his nails from breaking the skin in his palm.An observation of Resident #24's palm and interview on 01/22/26 at 10:32 AM with the Certified Occupational Therapy Assistant (COTA) revealed the resident was not currently on caseload for OT but had been in the past. She stated when she had worked with him previously she had soaked his bilateral hands in warm water and cleaned them due to having moist exudate with an odor in his palm. The COTA observed his hands on 01/22/26 and noticed the reddened area caused by his middle finger nail and said he had an odor today in his right hand. An interview on 01/22/26 at 4:35 PM with Unit Manager #2 revealed she was not aware until today (01/22/26) that Resident #24 had a reddened place on his right palm caused by his middle fingernail.An interview on 01/23/26 at 12:14 PM with the Wound Nurse revealed no one had notified her of any skin issue on Resident #24's right hand. She stated if there had been an area on his palm the staff should have notified her so that she could put treatment in place for the area. A follow up interview on 01/23/26 at 3:35 PM with the DON revealed it was her expectation that the nurses assess resident's skin on the weekly skin assessments and identify any new skin issues and notify the appropriate discipline. The DON stated the Nurse Aides (NAs) and nurses caring for Resident #24 should have noticed the area on his palm caused by his fingernail and it should have been documented and treatment put into place to treat it and therapy consulted to evaluate him for a different type of palm guard. An interview with the Administrator on 01/23/26 at 3:50 PM revealed he was disappointed that his staff had not assessed and addressed Resident #24's reddened area to his palm. He stated it was his expectation that staff assess and address any skin issues on residents as soon as possible.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, record reviews and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 28 opportunities, resulting in a medication error rate of 7.14% for 2 of 4 residents observed during medication administration (Resident #62 and Resident #112).The findings included:1. The manufacturer's instructions for prefilled Tresiba insulin pen indicated the pen contained long-acting insulin that was injected once daily subcutaneously in the thigh, abdomen or upper arm. Prime the pen with 2 units before each dose. Priming the pen (essential): turn the dose selector to 2 units, hold the pen with the needle up, tap gently, and press the button until the counter shows 0 and a drop of insulin appears. Resident #112's medical record revealed a physician order dated 12/06/25 for Tresiba insulin via pen injector, inject 20 units subcutaneously one time a day for diabetes mellitus. On 01/22/26 at 9:10 AM an observation was made of Nurse #5 preparing to administer insulin to Resident #112 via an insulin pen. The Nurse removed the Tresiba insulin pen from the medication cart and set the counter to 20 units. Nurse #5 administered the 20 units of insulin without priming the insulin pen as advised by the manufacturer's instructions.An interview was conducted with Nurse #5 at 11:35 AM on 01/22/26. The Nurse was asked to explain the procedure when giving insulin using an insulin pen and Nurse #5 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 knew she should have primmed the pen and thought she had primed the pen before giving Resident #112 the insulin.An interview was conducted with the Director of Nursing (DON) on 01/22/26 at 12:55 PM. The DON explained that she had already heard that Nurse #5 did not prime the pen before giving the insulin. She stated she watched a video about the correct way to inject the insulin using a pen and the video showed to prime the insulin to ensure insulin was in the needle before it was injected into the resident.During an interview with the Pharmacy Consultant on 01/22/26 at 1:55 PM the Pharmacy Consultant explained priming the insulin pen was recommended especially with small doses because there could be air bubbles in the chamber of the pen and the air bubbles needed to be removed to ensure the resident was getting the full amount of insulin ordered.2. Review of Resident #62's physician orders dated 01/13/26 revealed fluticasone furoate one spray in both nostrils one time a day for 30 days for sinus/allergies.On 01/22/26 at 9:30 AM Nurse #5 was observed as she prepared and administered Resident #62's medications. The Nurse administered fluticasone furoate 2 sprays in each nostril.An interview was conducted with Nurse #7 on 01/22/26 at 12:35 PM. The Nurse recounted her actions when giving Resident #62 her nasal spray earlier and stated she gave the Resident 2 sprays in each nostril. Nurse #7 read the order for the nasal spray which stated to give one spray in each nostril and stated she should have read the order closer.During an interview with the Director of Nursing (DON) on 01/22/26 at 12:55 PM the DON stated that she had already heard about the medication error made by Nurse #7 and explained that Nurse #7 should give the medication according to the five rights which would have ensured she gave the correct dose.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with the Resident Council, staff and residents, the facility failed to provide a meal that was palatable in taste and temperature for 3 of 4 residents reviewed for palatable food (Resident #9, Resident #10, and Resident #23). The findings included:1.Resident #9 was admitted to the facility on [DATE].Resident #9's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was cognitively intact.Review of facility provided grievance logs revealed Resident #9 filed a grievance on 07/02/25 regarding the presentation and appealing nature of the meal trays being served. Per the grievance, Resident #9 complained that there was excess liquid saturating the meal plates. The facility investigated the grievance and determined that there was excess liquid from the vegetables and indicated that vegetables would be served separately moving forward.An interview with Resident #9 on 01/20/26 at 12:15 PM revealed he had multiple concerns about the quality and the presentation of food served in the facility. Resident #9 reported food was often undercooked, there was a lot of grease or other liquids that run into the different foods on the meal trays, toast was burnt, and mashed potatoes are extremely runny. Resident #9 stated he had voiced his concerns but indicated that the quality and presentation of the meal trays had not improved. 2. Resident #10 was admitted to the facility on [DATE].Resident #10's quarterly MDS assessment dated [DATE] revealed Resident #10 was cognitively intact.An interview with Resident #10 on 01/20/26 at 2:12 PM revealed that the meal trays were often cold and did not have good flavor or texture.3. Resident #23 was admitted to the facility on [DATE].Review of Resident #23's quarterly MDS assessment dated [DATE] revealed Resident #23 was cognitively intact with no delusions, behaviors, or rejection of care.An interview with Resident #23 on 01/20/25 at 12:52 PM revealed he was not pleased with the quality or temperature of the food served on the meal trays. He described the meal trays as looking like vomit and stated most days the meals were cold when they arrived at his room.An observation of food temperatures on the meal service line completed on 01/21/26 at 12:02 PM revealed all foods were above the minimum holding temperature of 135 degrees Fahrenheit (F) and ranged from 161 - 185 degrees.After obtaining temperatures of the food items on the tray service line on 1/21/25, the Dietary Manager was informed of a request for two test trays, one of the main meal and one of the alternate offering meal. The test trays were plated at 12:23 PM and left the kitchen at 12:26 PM. The test trays arrived on the hall at 12:29 PM and the first tray delivered to a resident occurred at 12:32 PM with the final tray being delivered to a resident occurred at 12:41 PM. The following were the observations of the two requested test trays that occurred at 12:45 PM:Test Tray #1 consisted of sliced ham, broccoli, yams, and a dinner roll. When the dome lid was removed, there was no observable steam rising from the plate. The ham was observed to be warm, but not hot with good flavor and good texture. The broccoli was cool but had good flavor and still had some crunch, indicating that it had not been overcooked. The yams were mushy and no real flavor outside of what was already prepared when they were canned. The yams were also warm but not hot. The dinner roll was almost room temperature but had a good crust on the outside but remained soft on the inside.Test Tray #2 consisted of chicken tenders, diced cabbage, rice, and a dinner roll. When the dome lid was removed there also was no observable steam rising from the plate. The chicken tenders were warm but not hot, they appeared pale and the breading was soft and mushy. The diced cabbage was warm but not hot with an overwhelming flavor of butter when tasted, almost drowning out any flavor of cabbage. The rice was warm, tender and tasted like plain white rice. There was observable liquid bleeding from the cabbage and into the chicken tenders and rice. The dinner roll was almost room temperature but had a good crust on the outside but remained soft on the (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inside.An interview with the Dietary Manager on 01/21/26 at 12:53 PM revealed the test tray meals were not warm but that test tray #2 held the temperature better than test tray #1. She stated the exterior of the chicken tenders did look pale, soft, and not crispy as you would expect fried chicken tenders to be but stated it also could be from the type of breading used on the chicken tenders as they are precooked and shipped to the facility frozen. She also indicated that the mushy breading of the chicken tenders could be caused by steam from the meal getting trapped in the dome lid and causing the breading to become soft. During a follow up interview with Resident #9 on 01/21/26 at 12:32 PM, Resident #9 reported that his meal tray had broccoli and 2 chicken tenders. Resident #9 reported the chicken tenders were pale in color and reported overall, the meal was just okay. Resident #9 declined wanting anything else or different from the facility's kitchen.During a follow up interview with Resident #10 on 01/21/26 at 1:12 PM, Resident #10 reported on a scale of 1 to 3, 1 being terrible and 3 being great, that he would rate his meal as a 1. Resident #10 reported he received a meal that consisted of chicken tenders, mashed potatoes, cabbage, a dinner roll and dessert. Resident #10 indicated that the meal was cool and did not have a good appearance.During a follow up interview with Resident #23 on 01/21/26 at 3:16 PM, Resident #23 reported his while his lunch meal was better than it normally was, he did not eat all of it, but it still was not very appetizing and was not very warm.During the Resident Council group interview completed on 01/22/26 at 11:02 AM, the attending residents reported that there were issues with the food served from the kitchen. The interviewed residents (Resident #53, Resident #54, Resident #108, and Resident #111) reported their main food complaints had to do with lack of seasoning of food and the over or undercooking of various food items. During a follow up interview with the Dietary Manager on 01/21/26 at 1:26 PM, she reported the facility does have a Food Committee that consists of residents within the facility and that they meet monthly to review any food concerns and to talk about what menu items are working or if there need to be changes made to the menus. She indicated that most of the complaints that she heard from the food committee dealt with individual preferences and stated that she believed that the majority of temperature complaints regarding the meal trays had more to do with how long the meal trays sat on the halls before the floor staff pass them out. The Dietary Manager continued, stating that for a resident like Resident #23, whose room was at the end of a hall, if the meal trays were not passed timely, it could result in his meal tray not being warm.During an interview with the Administrator on 01/23/26 at 3:54 PM he revealed he had received some complaints about the food served from the kitchen. He reported most of the complaints were preference-related and he felt they had been handled. The Administrator reported it was very difficult to please over 100 residents but stated there should not be as many complaints about the quality and temperature of the food as there had been reported. The Administrator stated he had not had a test tray from the kitchen in some time and stated with the amount of food complaints being brought to his attention, he should be requesting a test tray more often.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER The Greens at Hickory		STREET ADDRESS, CITY, STATE, ZIP CODE 3031 Tate Boulevard SE Hickory, NC 28602	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to maintain a complete and accurate medical record that included the medications given in error for 1 of 1 resident reviewed for accuracy of medical records (Resident #83).The findings included:Resident #83 was admitted to the facility on [DATE].Review of Resident #83's medical record revealed a Change in Condition form dated 11/06/25 and completed by the Director of Nursing (DON) which indicated that the form was being completed because of a medication variation on the night of 11/06/25. Resident #83's vital signs were taken after the medication variation at 10:14 PM and recorded as blood pressure 130/62 (normal range is between 120/80 and 90/60), pulse 66 (normal pulse is between 60 and 100 beats per minute), respiratory rate 18 (normal range is between 12 to 20 breaths per minute), temperature 98.2 (normal body temperature is between 97.0 and 99.0), oxygen saturation 94% (normal oxygen saturation level is between 95% and 100%) and blood glucose 115 (normal blood sugar range is between 70-99 when fasting). The form noted Resident #83's allergies were penicillin and tuberculin solution. There were no changes in Resident #83's mental, physical and behavioral symptoms. The Resident, who was his own responsible party was made aware of the medication errors and the on-call physician service was made aware of the errors and gave orders to monitor Resident #83 for changes. The form did not indicate what medications were given to Resident #83.Review of Resident #83's medical record revealed there was no documentation in the Resident's medical record that indicated what medications were given to Resident #83 in error on 11/06/25.Multiple attempts were made to interview Nurse #8 on 01/23/26 at 3:43 PM and 01/26/26 at 10:00 AM but the attempts were unsuccessful. Nurse #8 was the Nurse who made the medication errors on 11/06/25.An interview was conducted with Supervisor #9 on 01/23/26 at 3:45 PM who explained that on 11/06/25 she was the acting second shift Supervisor when Nurse #8 informed her of medication errors that she made by giving Resident #83 Resident #33's medications. Supervisor #9 continued to explain that she did not document the medications that were given to Resident #83 in error on 11/06/25 because Nurse #8 should have documented the medication errors since she was the Nurse who made the errors. The Supervisor stated she was not aware that Nurse #8 did not document the medications she gave Resident #83 in error on 11/06/25.An interview was conducted with the Director of Nursing (DON) on 01/28/26 at 10:00 AM. The DON explained that on the night of 11/06/25 Nurse #8 administered Resident #33's medications to Resident #83 by mistake and immediately reported her mistake to Supervisor #9. The DON acknowledged that neither Nurse #8 or Supervisor #9 documented the specific medications that were given to Resident #83 by mistake on 11/06/25 in the Resident's medical record and stated the documentation should have been entered into the medical record at the time of the incident. The DON indicated she should have included all the medications that were given to Resident #83 when she completed the Change in Condition form on 11/06/25. The DON added that she expected the nurses to document accurately in the residents' medical record as situations develop and that included the specific medications that were given to Resident #83 on 11/06/25 in error.