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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to obtain consent and inform the resident or responsible party in advance of the risks and benefits of psychotropic medications (any medication that affects behavior, mood, thoughts, or perception) prior to the initiation of the anticonvulsant and mood-stabilizing medication divalproex sodium for 3 of 6 residents reviewed for unnecessary medications (Resident #8, Resident #11, and Resident #16).The findings included:1. Resident #8 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, psychotic mood disturbance and anxiety, depression, and anxiety disorder.An admission Minimum Data Set (MDS) dated [DATE] revealed Resident #8 was severely cognitively impaired. The MDS indicated Resident #8 received antianxiety, antidepressant, and antipsychotic medications on a routine basis during the 7-day look back period. A Psychiatric Nurse Practitioner progress note dated 12/16/25 indicated Resident #8 had increased aggressive behavior with residents, displayed hoarding behaviors, and visual hallucinations. The plan recommended to start divalproex sodium (an anticonvulsant medication used primarily to treat seizures, mood disorders and bipolar disorder) 125 milligrams by mouth twice daily.Resident #8's physician orders revealed an order dated 12/17/25 through 12/30/25 for divalproex sodium 125 milligrams by mouth twice a day for unspecified dementia, psychotic mood disorder, and anxiety. An order dated 12/30/25 through 1/20/26 for divalproex sodium 250 milligrams by mouth twice daily for unspecified dementia, psychotic mood disorder, and anxiety. An order dated 1/20/26 and ongoing for divalproex sodium 500 milligrams by mouth twice daily for unspecified dementia, psychotic mood disorder, and anxiety.A review of Resident #8's medical record revealed no documentation that Resident #8's representative consented to or was informed in advance of the risks versus benefits of initiating divalproex sodium. The Medication Administration Record (MAR) from 12/17/25 to 01/21/26 indicated Resident #8 was administered divalproex sodium as ordered by the physician.An interview with Unit Manager #4 was conducted on 01/21/26 at 3:02 PM. Unit Manager #4 stated she was responsible for providing education about the risk versus benefits of medication and obtaining consent for psychotropic medications. Physician orders were reviewed daily for new psychotropic medications, and any new medications should have consent before initiating the medication. The Unit Manager #4 stated she did not obtain consent for divalproex sodium for Resident #8 from her responsible party because it was overlooked.An interview with the Director of Nursing (DON) was conducted on 01/23/26 at 9:20 AM. The DON stated she was responsible for providing education about the risk versus benefits of medication and obtaining all psychoactive medication consents. Medication changes and new orders were discussed daily in the morning team meeting. All new physician orders were printed and reviewed daily. The DON stated she was busy with other things, and the medication consents for divalproex were overlooked. The DON verbalized she had not obtained a consent from Resident #8's responsible party for divalproex sodium. The DON stated that all psychotropic medication consents should be in place prior to initiating psychotropic medication. An interview with Administrator was conducted on 01/23/26 at11:58 AM. The Administrator stated that he expected informed consents including a discussion of the risks and benefits to be obtained prior to starting or changing psychotropic medication.2. Resident #11 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, Alzheimer's disease, bipolar disorder, and delusional disorder.A significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #11 was severely cognitively impaired. The MDS indicated Resident #11 received antidepressant, anticonvulsant, and antipsychotic medications on a routine basis during the 7-day look back period. A Psychiatric Nurse Practitioner progress note dated 09/23/25 indicated Resident #11 had increased irritability with interview and (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment. Nursing staff reported ongoing episodes of anger and agitation. The recommendation was to start divalproex sodium (an anticonvulsant medication used primarily to treat seizures, mood disorders and bipolar disorder) 125 milligrams by mouth daily.Resident #11's physician orders revealed an order dated 09/23/25 through 11/06/25 for divalproex sodium 125 milligrams by mouth daily for unspecified dementia and bipolar disorder. An order dated 11/06/25 through 11/25/25 for divalproex sodium 125 milligrams by mouth twice daily for unspecified dementia and bipolar disorder. An order dated 11/25/25 through 12/30/25 for divalproex sodium 250 milligrams by mouth twice daily for unspecified dementia and bipolar disorder. An order dated 12/30/25 and ongoing for divalproex sodium 500 milligrams by mouth twice daily for unspecified dementia and bipolar disorder.A review of Resident #11's medical record revealed no documentation that Resident #11's representative consented to or was informed in advance of the risks versus benefits of initiating divalproex sodium.The Medication Administration Record (MAR) from 09/23/25 to 01/21/26 indicated Resident #11 was administered divalproex sodium as ordered by the physician. An interview with Unit Manager #4 was conducted on 01/21/26 at 3:02 PM. Unit Manager #4 stated she was responsible for providing education about the risk versus benefits of medication and obtaining consent for psychotropic medications. Physician orders were reviewed daily for new psychotropic medications, and any new medications should have consent before initiating the medication. The Unit Manager #4 stated she did not obtain consent for divalproex sodium for Resident #11 from her responsible party because it was overlooked.An interview with the Director of Nursing (DON) was conducted on 01/23/26 at 9:20 AM. The DON stated she was responsible for providing education about the risk versus benefits of medication and obtaining all psychoactive medication consents. Medication changes and new orders were discussed daily in the morning team meeting. All new physician orders were printed and reviewed daily. The DON stated she was busy with other things, and the medication consents for divalproex were overlooked. The DON verbalized she had not obtained a consent from Resident #11's responsible party for divalproex sodium. The DON stated that all psychotropic medication consents should be in place prior to initiating psychotropic medication. An interview with Administrator was conducted on 01/23/26 at11:58 AM. The Administrator stated that he expected informed consents including a discussion of the risks and benefits to be obtained prior to starting or changing psychotropic medication.3. Resident #16 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, major depressive disorder, hallucinations, and anxiety disorder.A Psychiatric Nurse Practitioner progress note dated 03/07/25 indicated Resident #16 had increased agitation during the evening hours including cursing and yelling at staff and peers. The plan recommended to start divalproex sodium (an anticonvulsant medication used primarily to treat seizures, mood disorders and bipolar disorder) 250 milligrams by mouth twice daily for disturbed mood and anxiety.Resident #16's physician orders revealed an order dated 03/07/25 through 04/28/25 for divalproex sodium 250 milligrams by mouth twice a day for unspecified dementia and anxiety.An order dated 04/28/25 through 11/13/25 for divalproex sodium 375 milligrams by mouth twice daily for unspecified dementia and anxiety. An order dated 11/13/25 and ongoing for divalproex sodium 500 milligrams by mouth twice daily for unspecified dementia and anxiety.The Medication Administration Record (MAR) from 10/01/25 to 01/21/26 indicated Resident #16 was administered divalproex sodium as ordered by the physician. A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #16 was severely cognitively impaired. The MDS indicated Resident #16 received antidepressant, anticonvulsant, and antipsychotic medications on a routine basis during the 7-day look back period. A review of Resident #16's medical record revealed no documentation that Resident #16's representative consented to or was informed in advance of the risks versus benefits of initiating divalproex sodium.An interview with Unit Manager #4 was (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted on 01/21/26 at 3:02 PM. Unit Manager #4 stated she was responsible for providing education about the risk versus benefits of medication and obtaining consent for psychotropic medications. Physician orders were reviewed daily for new psychotropic medications, and any new medications should have consent before initiating the medication. The Unit Manager #4 stated she did not obtain a consent for divalproex sodium for Resident #16 from her responsible party because it was overlooked.An interview with the Director of Nursing (DON) was conducted on 01/23/26 at 9:20 AM. The DON stated she was responsible for providing education about the risk versus benefits of medication and obtaining all psychoactive medication consents. Medication changes and new orders were discussed daily in the morning team meeting. All new physician orders were printed and reviewed daily. The DON stated she was busy with other things, and the medication consents for divalproex were overlooked. The DON verbalized she had not obtained a consent from Resident #16's responsible party for divalproex sodium. The DON stated that all psychotropic medication consents should be in place prior to initiating the medication.An interview with Administrator was conducted on 01/23/26 at11:58 AM. The Administrator stated that he expected informed consents including a discussion of the risks and benefits to be obtained prior to starting or changing psychotropic medication.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to have advanced directives accurate throughout the medical record for 2 of 2 residents reviewed for advanced directives (Resident #8 and Resident #32). The findings included: 1. Resident #32 was admitted to the facility on [DATE]. Resident #32's care plan initiated on 04/18/25 indicated Resident #32's health directive was a full code. Interventions included to call 911 immediately and to intercede rapidly and begin immediate resuscitative efforts utilizing all life-sustaining measures available if the resident's heart stops beating, or the resident stops breathing such as cardiopulmonary resuscitation, oxygen administration and defibrillation. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #32's cognition was intact. A review of Resident #32's medical record indicated a physician's order dated 01/12/26 for Do Not Resuscitate (DNR). On 01/20/26 at 3:20 PM a review of the advance directive binder at the nurses' station revealed a DNR form for Resident #32 which was dated 01/12/26. An interview was conducted on 01/22/26 at 4:25 with Minimum Data Set (MDS) Coordinator who explained that it was the MDS Nurse's responsibility to update the care plans when necessary and Resident #32's care plan should have been updated on 01/13/26 during the morning team meeting when they reviewed all the new orders that were written the previous day. The MDS Coordinator stated she had been sick and out of work and came back on 01/13/26 and was not feeling well and missed revising Resident #32's care plan during the meeting. On 01/23/26 at 1:19 PM an interview was conducted with the Administrator who explained that he expected advanced directives to match throughout all the residents' medical records. 2. Resident #8 was admitted to the facility on [DATE]. A review of Resident #8's physician orders revealed an order for code status of do not resuscitate (DNR) dated 11/13/25. A care plan dated 11/14/25 included an area of focus for advanced directives. Resident #8 was noted to have a code status of DNR with a stated goal that no aggressive life-saving measures would be implemented. Interventions included effectively communicating DNR wishes by placing form in the front of the chart and when resident must be transferred outside the facility. An admission Minimum Data Set (MDS) dated [DATE] revealed Resident #8 was severely cognitively impaired. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #8's electronic medical record (EMR) revealed the advanced directive banner at the top of Resident #8's EMR page documented that her advance directive was DNR. An observation of the advanced directives notebook kept at the nurse's station revealed Resident #8 did not have a DNR form present in the notebook. On 01/21/26 at 2:49 PM an interview was conducted with Nurse #5 who explained that if she had to immediately determine a resident's code status, she would look in the resident's medical record on the computer and she would look in the advanced directives notebook kept at the nurse's station. Nurse #5 reported that if there was no DNR form in the code status notebook then the resident was determined to be a full code. Nurse #5 looked in the code status notebook for Resident #8's DNR form and acknowledged the form was not in the book. The Nurse stated she would determine Resident #8 to be a full code in the event of any emergency. An interview with Unit Manager #4 was conducted on 01/21/26 at 3:17 PM. Unit Manager #4 indicated that residents with DNR orders would have a DNR form completed by the Admissions Director when admitted to the facility. This form would be kept in the advanced directive notebook at the nurse's station for reference in the event of an emergency. The original form would go to the hospital with the resident if they were transferred. Unit Manager #4 indicated that Resident #8 was recently sent out to the hospital and her form must not have been returned with her. Unit Manager #4 explained that the nurse who received Resident #8 back from the hospital should have verified the form was in place. Unit Manager #4 verbalized she was responsible for checking the book weekly and had not recently checked it. Unit Manager #4 stated she did not check the notebook for the form after Resident #8 returned from the hospital. In the event of an emergency, the staff would follow the physician's order in absence of the DNR form. An interview was conducted with the Director of Nursing (DON) on 01/23/26 at 9:20 AM. The DON explained that if a resident was a DNR then there should be a DNR form in the advanced directive notebook at the nurse's station in case of an emergency. The DON verbalized that Resident #8 was recently transferred to the hospital and her DNR form did not return with her. The DON stated that Unit Managers should check the advanced directive books to ensure the correct forms were in place. The DON reported staff had not noticed the form was missing when Resident #8 returned from the hospital and the form was not replaced. An interview with the Administrator was conducted on 01/23/26 at 11:58 AM. The Administrator stated that the DNR forms should be available for facility and emergency staff in case a resident had an emergency.

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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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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to have evidence that a request for an evaluation for a Level II Preadmission Screening and Resident Review (PASRR) was submitted for a resident with a newly identified diagnosis of a serious mental health disorder for 1 of 2 residents reviewed for PASRR (Resident #3).Findings included:Resident #3 was admitted to the facility on [DATE].Review of Resident #3's Level I PASRR dated 04/13/22.Review of Resident #3's list of cumulative diagnoses revealed active diagnoses of Post Traumatic Stress Disorder (PTSD) dated 03/14/24 and Major Depressive Disorder, Recurrent Severe without Psychotic Features dated 03/19/24.The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #3's active psychiatric/mood disorder diagnoses included depression and PTSD. He received antidepressant medications during the MDS assessment period.A Psychiatric progress note dated 12/23/25 revealed Resident #3 was seen for follow-up of 1) major depressive disorder, recurrent severe without psychotic features with severity level low and stable and 2) PTSD with severity level low and stable. The progress note indicated Resident #3 was prescribed citalopram (antidepressant) 10 milligram one tablet by mouth every day for the depression and to continue to monitor for symptoms of depression and PTSD.A care plan last revised on 01/13/26 revealed Resident #3 has possible history of unknown traumatic event/experience as manifested by signs and symptoms of PTSD and recent suicidal ideations. Interventions included assisting Resident #3 in meaningful activities that match the Resident's abilities and interests, reducing any known stimuli that is known to trigger Resident #3's trauma and utilizing techniques such as art (coloring) to reminisce on past positive memories.Review of Resident #3's medical record revealed there was no Level II PASRR evaluation.The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR determination had been submitted for Resident #3.An interview was conducted with Social Worker (SW) #1 on 01/23/26 at 9:45 AM. The Social Worker reviewed Resident #3's medical record and reported that the Resident was admitted on [DATE] and did not have a diagnosis of PTSD. SW #1 stated the diagnosis for PTSD was added to the cumulative diagnosis listing on 03/14/24 and when the diagnosis was added she reviewed the medical record to see if Resident #3 was displaying any new behaviors which he was not, so she did not request a Level II PASRR screen. The SW stated she reviewed Resident #3's medical record to see if and when a request for a Level II PASRR evaluation had been submitted and could not find one. The SW stated she was employed at the facility before Resident #3 was admitted and she did not know of him to have any behaviors to warrant a Level II PASRR. The SW indicated if the Resident did require a Level II PASRR that he was already getting the psychiatric services that he would require.During an interview with the Administrator on 01/23/26 at 1:26 PM the Administrator stated his expectation was that a Level II PASRR's be requested when indicated of a new psychiatric diagnosis.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and resident, family member, staff, and Medical Director interviews, the facility failed to ensure medications were administered as prescribed by the physician when Nurse #8 administered medications to Resident #83 prescribed for Resident #33 which included Metformin (an antidiabetic agent), Coreg (beta-blocker that affects the heart and circulation), Trazadone (an antidepressant), Melatonin (hormone that regulates sleep), Senna (plant-based product used as laxative) and Tizanidine (muscle relaxant). In addition, Nurse #6 administered medications to Resident #139 prescribed for Resident #23 which included Tylenol (an analgesic) and Buspar (an anti-anxiety medication). This deficient practice affected 2 of 6 residents reviewed for medication errors. The findings included: 1. Resident #83 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus, hypertension, constipation, restless leg syndrome, hallucinations and major depressive disorder. Review of Resident #83's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact and received antidepressant and hypoglycemic medications during the look back period. Review of a Change in Condition form dated 11/06/25 and completed by the Director of Nursing (DON) 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 #33's Medication Administration Record (MAR) for November 2025 revealed the following medications that were administered to Resident #83 in error on 11/06/25: - melatonin (a hormone the body produces to regulate sleep-wake cycle) 5 milligrams (mg) tablet by mouth at bedtime for insomnia. - sennosides (laxative) 8.6 mg 2 tablets by mouth at bedtime for constipation. - tizanidine (muscle relaxant) 2 mg one tablet by mouth for muscle relaxant. - trazadone (antidepressant) 50 mg one tablet by mouth at bedtime for insomnia. - carvedilol (antihypertensive) 25 mg tablet by mouth twice a day for hypertension. - metformin (hypoglycemic) 1000 mg tablet by mouth twice a day for diabetes mellitus. (continued on next page)

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The Greens at Hickory	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a typed statement made by the Director of Nursing on 11/07/25 revealed the DON spoke with the second shift (3:00 PM to 11:00 PM) Supervisor #9 by phone who was present at the time of medication variation. Per Supervisor #9, Nurse #8 was assigned to Resident #83's and Resident #33's section and was in the process of completing her bedtime medication pass (on 11/06/25). When Nurse #8 arrived at Resident #83's and Resident #33's room, the Nurse pulled Resident #33's medications and mistakenly gave them to Resident #83. As soon as Nurse #8 realized that she had administered the wrong medications to Resident #83, Nurse #8 immediately informed Supervisor #9 of her mistake. Supervisor #9 then notified the on-call provider to let them know what had happened and received response from the on-call provider to monitor Resident #83 for any changes and notify the on-call provider of any changes. Per Supervisor #9, Nurse #8 checked Resident #83's vital signs twice within the first hour after the event occurred. Resident #83 was his own responsible party and was made aware of the situation. Nurse #8 informed the oncoming shift of what happened. It was documented that Nurse #8 was at her other place of employment and was unable to write/send a statement at this time. Review of Resident #83's vital signs taken after 10:14 PM on 11/06/25: - 11/07/25 at 4:48 AM, blood pressure 122/63, pulse 67, respiratory rate 16, oxygen saturation 93% - 11/07/25 at 8:17 AM, blood pressure 130/64, pulse 83, respiratory rate 20, oxygen saturation 96% - 11/07/25 at 5:13 AM, blood sugar 110 Review of a progress note written by the Director of Nursing on 11/07/25 at 11:05 AM revealed she spoke with the Medical Director regarding Resident #83 receiving Resident #33's medication last night at bedtime. Per the Medical Director the Resident's roommate was not on anything that could harm Resident #83. Received orders to check blood glucose and vital signs every six hours for forty-eight hours and neuro checks every six hours for twenty-four hours. Review of Resident #83's physician orders for 11/07/25 were: check blood glucose, vital signs every six hours for forty-eight hours and check neuro checks for every six hours for twenty-four hours and report any abnormal results to the provider immediately. Review of Resident #83's medical record revealed the Resident's vital signs, blood sugars and neurological checks were obtained as ordered with no abnormal findings. Review of the Nurse Practitioner's (NP) progress note dated 11/07/25 included the Resident and nurse stated he was given the wrong medication yesterday, he was given metformin, coreg and trazadone by the nurse accidently that belonged to his roommate. There was no further mention in the note by the NP regarding the medication errors. An interview was conducted with Resident #83 on 01/23/26 at 1:04 PM who explained that he remembered when he was given Resident #33's medications. He stated that the nurses kept checking on him and he did not suffer any ill effects from the medications. Attempts were made to interview Nurse #8 by telephone on 01/23/26 at 3:43 PM and 01/26/26 at 10:00 AM but were unsuccessful. An interview was conducted with Supervisor #9 on 01/23/26 at 3:45 PM who explained that on 11/06/25 she was acting second shift Supervisor when Nurse #8 informed her of a medication error that she (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	made by giving Resident #83 Resident #33's medications. Supervisor #9 continued to explain that she immediately called the on-call provider and reported the medication errors, and the doctor told her to monitor Resident #83's vital signs and to call them back if there were any changes. The Supervisor stated Resident #83 had no negative effects from receiving the wrong medications. She reported that Resident #83 was his own responsible party, and she explained to him that Nurse #8 gave him Resident #33's medications and encouraged him to report any changes that he may experience which the Resident did not report any changes. Supervisor #9 stated she reported the incident to the oncoming Supervisor #10. An interview was conducted with the third shift (11:00 PM-7:00 M) Supervisor #10 on 01/26/26 at 10:05 AM. The Supervisor explained that she remembered the night of the medication error 11/06/25 and was notified of the medication error by Supervisor #9. Supervisor #10 continued to explain that Resident #83 was monitored throughout the night and there were no changes in his vital signs that would warrant notifying the physician. Interviews were conducted with the Director of Nursing (DON) on 01/23/26 at 1:28 PM and 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. Supervisor #9 called the on-call doctor and reported the medication errors to the doctor, and the doctor gave orders to monitor Resident #83 for any changes and to hold Resident #83's other bedtime medications. She continued to explain that Resident #83 had no negative side effects from the medication and in fact, Resident #83 was on some of the medications that were given to him by mistake. The DON reported the next day, on 11/07/24, the Nurse Practitioner saw Resident #83 and gave orders to monitor his vital signs and blood sugar every six hours for forty-eight hours and to monitor neurological checks every six hours for twenty-four hours and Resident #83 had no negative effects from the medication errors. The DON explained that the only explanation for the medication errors was that Nurse #8 who was an agency Nurse, did not check the five rights before she administered the medications to Resident #83. She stated Nurse #8 was immediately terminated from working at the facility for not following facility protocol for medication administration. The DON stated she expected all the nurses to practice safe medication pass such as checking the five rights of medication administration. During an interview with the Administrator on 01/23/26 at 1:45 PM the Administrator stated he expected the nurses to practice medication administration by checking the five rights of safe medication administration before they administer the residents' medications. An interview was conducted with the Medical Director on 01/23/26 at 1:50 PM. The Medical Director indicated that the medication errors were unfortunate and that Resident #83 did not have any negative side effects from the medications. He stated Resident #83 was prescribed some of the medications that he received and he did not consider the medication errors to be significant. 2. Resident #139 was admitted to the facility on [DATE] and discharged on 12/16/25. His admitting diagnoses included end stage renal disease dependent on dialysis, coronary artery disease, hypertension, diabetes mellitus type II, and chronic obstructive pulmonary disease. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #139 was cognitively intact. The MDS revealed Resident #139 received antidepressant and hypoglycemic medications during the assessment period but had not received anti-anxiety medication. A review of the physician orders dated October 2025 revealed Resident #139 was prescribed the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following medications but none were scheduled for 2:00 PM: Duloxetine HCl oral capsule delayed release sprinkle 20 milligrams (mg) 1 capsule by mouth one time a day for depression. Insulin Glargine Solostar Subcutaneous Solution Pen-Injector 100 units/milliliter (ml) Inject 18 units subcutaneously one time a day for diabetes mellitus type II. Levothyroxine Sodium oral tablet 100 micrograms (mcg) 1 tablet by mouth one time a day for hypothyroidism. Pravastatin Sodium oral tablet 1 tablet by mouth one time a day for hyperlipidemia. Insulin Aspart Subcutaneous Solution Pen-Injector 100 units/ml Inject 5 units subcutaneously with meals for diabetes mellitus. Hold if blood sugar is less than 150. Resident #23 was admitted to the facility on [DATE] with diagnoses which included spastic hemiplegia following stroke, diabetes mellitus type II and chronic pain syndrome. A review of the physician orders dated October 2025 revealed Resident #23 was prescribed the following medications: Acetaminophen oral tablet 325 mg 3 tablets by mouth three times a day for pain at 8:00 AM- 2:00 PM- 8:00 PM Buspirone HCl oral tablet 7.5 mg 1 tablet by mouth three times a day for anxiety at 8:00 AM- 2:00 PM- 8:00 PM Review of Resident #139's Situation, Background, Appearance, Review and Notify (SBAR) Communication Form dated 10/26/25 revealed Resident #139 had received Resident #23's medication during a 2:00 PM medication pass. The medications Resident #139 received were Acetaminophen (an analgesic) 325 mg three tablets and Buspirone HCl (Hydrochloride) (an antianxiety medication) 7.5 mg 1 tablet. The incident was discovered when Resident #139's family member asked Nurse # 2 (family member could not find Nurse #6 who had administered the medication) what medications Resident #139 had received at 2:25 PM because he usually did not take medicines at that time. Nurse #2 looked at the Medication Administration Record (MAR) for Resident #139 and discovered he was not ordered medications at 2:00 PM and asked the family member what the pills looked like. The family member was able to describe he had taken 3 white oblong pills that appeared to be all the same and one white small round pill. Nurse #2 reviewed the records of the residents that were administered medications by Nurse #6 and discovered that Resident #139 had received Resident #23's 2:00 PM medications. Nurse #6 immediately notified the on-call provider who reviewed the medications Resident #139 was on and determined there was no drug interaction with the medications he had received belonging to Resident #23. The on-call provider gave orders to monitor Resident #139's vital signs every 6 hours for 24 hours and report any change in his condition. Nurse #2 notified the family member and the resident of the medication error and the orders for his vital signs to be monitored every 6 hours for 24 hours. The family member and resident were notified of the error on 10/26/25 at 2:27 PM. The Assistant Director of Nursing (ADON) was notified of the medication error on 10/26/25 at 2:32 PM and the DON was notified of the medication error on 10/26/25 at 2:58 PM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a typed statement dated 10/26/25 made by Nurse #2 revealed at approximately 2:20 PM Resident #139's family member approached Nurse #2 and asked her if Resident #139's medications had changed. Nurse #2 explained to the family member that she had not been assigned to Resident #139 earlier but she could check his electronic medical record (EMR) and review his current medications with her. Nurse #2 verified the family member was listed in the EMR as his emergency contact before providing the information. Nurse #2 informed the family member of the medications Resident #139 should have received and the family member then asked what he received after lunch and Nurse #2 stated he did not have medications ordered after lunch. The family member then stated to Nurse #2 that Nurse #6 had brought medications in for the resident after lunch and the cup was still in the room but said the resident had taken the medications. Nurse #2 told the family member that she would discuss this with the weekend supervisor and get back to her about the medications Resident #139 had taken. Nurse #2 made Unit Manager #1 aware of the situation, and they began reviewing the MARs of all the residents Nurse #6 had medicated during the 7:00 AM to 3:00 PM shift. Nurse #6 had been sent home when she had completed her medication pass and documentation and was not at the facility at the time the error was discovered. Nurse #2 and Unit Manager #1 discovered that Resident #139 had been administered medications that were ordered to be given to Resident #23 at 2:00 PM. Nurse #2 and Unit Manager #1 explained what had happened to the family member and Resident #23. Nurse #2 explained to them that the on-call provider was being contacted as well as the ADON and Director (DON) to inform them of the medication error. A telephone interview on 01/20/26 at 3:29 PM with Resident #139's family member revealed Resident #139 had received medications on 10/26/25 that were not prescribed to him. The family member stated Nurse #6 brought 4 pills (3 white oblong pills and 1 white small round pill) in a cup into his room around 2:30 PM and gave them to him. The family member stated she was not aware of him taking medications at that time of day, so she had gone out a few minutes later and asked Nurse #2 (could not find Nurse #6) what the medications were that Resident #139 had received. She stated Nurse #2 came back to her later and told her that Resident #139 had received medications that were prescribed for another resident (Resident #23). A telephone interview on 01/22/26 at 2:01 PM with Nurse #2 revealed she was working on 10/26/25 on the 7:00 AM to 3:00 PM shift with Nurse #6 and after Nurse #6 had left for the day discovered that she had administered medications to Resident #139 that were prescribed for Resident #23. She stated the family member had made her aware that Nurse #6 had brought medications into Resident #139's room around 2:00 PM and asked if his medications had changed. Nurse #2 said she reviewed Resident #139's medications with the family member and discovered he had no medications ordered to be given at 2:00 PM. Nurse #2 explained that she then notified Unit Manager #1 that Resident #139 had been administered medications that were not prescribed for him and said they began reviewing the MARs for all the residents Nurse #6 had administered medications to during her shift. Nurse #2 said they discovered that Resident #139 had received medications prescribed for Resident #23 during the 2:00 PM medication pass. She stated she explained what had happened to the family member and Resident #139 and immediately called the on-call provider, ADON, and DON to notify them of the error. Nurse #2 stated the on-call provider reviewed Resident #139's medications and the medications he had received that were not prescribed for him and determined there was no drug interaction and no listed allergies for Resident #139 to the medications. Nurse #2 further stated the on-call provider had given order to monitor Resident #139's vital signs every 6 hours for 24 hours and notify him if there were any changes in the resident. Nurse #2 stated Unit Manager #1 called the agency that employed Nurse #6 and made her do not return to the facility with her agency to prevent any future medication errors. An interview on 01/22/26 at 1:43 PM with Unit Manager #1 revealed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she was the Weekend Supervisor on 10/26/25 and remembered getting a call from Nurse #2 that Resident #139 had received medications that were not prescribed for him. Unit Manager #1 stated she and Nurse #2 began looking at the residents the agency nurse (Nurse #6) had medicated to try to determine the medications Resident #139 had taken. She stated they discovered based on the description of the pills from the family member that Resident #139 had taken the 2:00 PM medications prescribed for Resident #23. Unit Manager #1 stated they immediately contacted the on-call provider and reviewed Resident #139's medications with him and the medications he had taken. Unit Manager #1 said Resident #139 had taken Acetaminophen 325 mg 3 tablets and Buspirone HCl 7.5 mg 1 tablet and the provider determined there was no drug interactions, so he gave orders to monitor Resident #139 and take his vital signs every 6 hours for 24 hours and call with any change in his condition. Unit Manager #1 said she and Nurse #2 then went into Resident #139's room and explained to him and the family member what had happened and what the provider had instructed them to do for the resident. She said they both understood and then she stated she notified the ADON and DON about the medication error and called the agency the nurse worked for and made her do not return to avoid any future medication errors. Several attempts were made to contact Nurse #6 but they were unsuccessful. Review of a verbal order given by the on-call provider on 10/26/25 revealed the following: Monitor vital signs every 6 hours for 24 hours and notify provider of any changes. Resident #139's documented vital signs dated 10/26/25 at 5:30 PM revealed the following: blood pressure (BP) 145/79 (normal range systolic (top number) less than 120 and diastolic (bottom number) less than 80), temperature (T) 98.0 (normal range 97 to 99), pulse (P) 79 beats per minute (normal range 60-100), respirations (R) 16 breaths per minute (normal range 12-20), oxygen saturation 96% (normal range 92% or higher) on room air. His documented vital signs on 10/27/25 at 6:39 AM were BP 140/80, T 97.8, P 80, R18, and oxygen saturation 97% on room air. Resident #139's documented vital signs on 10/27/25 at 11:03 AM were BP 132/75, T97.5, P 61, R16, and oxygen saturation 97 % on room air. His documented vital signs on 10/27/25 at 4:46 PM were BP 122/74, T98, P 62, R16, and oxygen saturation 98%. Resident #139's documented vital signs on 10/27/25 at 7:31 PM were BP 137/74, T 97.9, P 72, R 18, and oxygen saturation 97% on room air. Review of an interdisciplinary team (IDT) risk meeting progress note dated 10/27/25 revealed the following: It was noted that resident did receive medication that was not prescribed for him. On-call provider was notified immediately and no concerns regarding medication interaction. A verbal order was given by on-call provider to monitor vital signs every 6 hours for 24 hours and notify provider of any changes. The DON and Assistant DON (ADON) were notified as well as the resident and his family member. The agency nurse was the nurse who administered the medications and she was DNR (do not return) from the facility to assist in preventing future incidents. An interview on 01/23/26 at 3:35 PM with the Director of Nursing (DON) revealed she had been made aware of the medication error by Unit Manager #1 and ADON on 10/26/25. She stated she had instructed them to call the on-call provider to notify him of the medication error and to let her know the orders obtained from him. The DON stated she didn't understand why the family member allowed the resident to take the medications if she knew he didn't take medications at that time of day but said the medications should not have been given to Resident #139 and it was the nurse's error for giving him medications prescribed to another resident. The DON stated Nurse #6 who gave the wrong medications was made do not return to facility with her agency to prevent another medication error from happening. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 01/23/26 at 3:50 PM with the Administrator revealed he was aware of the medication error and was disappointed that the medication error had occurred. He stated they were working diligently to hire their own staff so they would not have to use agency but said they still needed agency to fill shifts where they have vacancies. The Administrator stated he did think his staff had acted promptly and appropriately once the error was discovered but stated it was unfortunate for Resident #139 that he had been given another resident's medication. An interview on 01/23/26 at 1:50 PM with the Medical Director revealed that he had heard about the medication error with Resident #139 receiving medications that belonged to Resident #23. The Medical Director indicated that while it was unfortunate the medication error had occurred Resident #139 did not have any negative side effects from the medications. He further stated he did not consider the medications given to Resident #139 in error to be significant medication errors.

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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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The Greens at Hickory	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 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.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with the resident, Registered Dietitian (RD) and staff, the facility failed to follow the physician's diet order to provide double portions for 2 of 5 residents reviewed for nutrition (Resident #10 and Resident #2).Findings included: 1. Resident #10 was admitted to the facility 07/08/25 with a diagnosis including hypothyroidism (underactive thyroid). Resident #10 had a physician order dated 07/09/25 for a regular diet with double portions for weight management. A summary of the Registered Dietitian (RD) note dated 11/04/25 was as follows: Resident #10 was seen for a significant weight change and skin review. Resident #10 had a good appetite with his current diet order (regular, cardiac/no salt, double portions) and usually ate 75-100% of meals. The RD note further stated she added double portions to all meals for weight management and increased kilocalorie (unit of energy) intake and this helped stabilize Resident #10's weight. The care plan for nutrition last revised 11/09/25 revealed Resident #10 had the potential for a nutritional problem related in part to a history of unintentional weight loss. Interventions included providing Resident #10's diet as ordered and monitoring his dietary intake. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was cognitively intact, weighed 151 pounds, and had not had any weight gain or weight loss. An observation of Resident #10's lunch meal ticket on 01/21/26 at 1:12 PM revealed he was to receive a regular diet with double portions. An observation of Resident #10's meal tray at the same date and time revealed he received 2 chicken tenders, one serving of mashed potatoes, one serving of cabbage, and one dinner roll. Resident #10 had just received his meal tray at the time of the observation. An interview with Resident #10 on 01/21/26 at 1:12 PM revealed he was supposed to get double portions for meals, and he had only received double portions approximately twice since he was admitted . Resident #10 stated he could eat 4 chicken tenders if he had them. An observation of Resident #10's meal tray with the Dietary District Manager on 01/21/26 at 1:19 PM revealed Resident #10 had not received a double portion of chicken tenders on his plate. The Dietary District Manager stated double portions were considered to be two servings of protein and Resident #10 should have received four chicken tenders. An interview with the Dietary Manager on 01/21/16 at 1:26 PM revealed that since Resident #10 had a physician order for double portions he should have received four chicken tenders on his lunch meal plate. The Dietary Manager stated the last person on the meal tray line was responsible for checking meal trays to ensure meal plates matched tray cards. An interview with Dietary Aide #1 on 01/21/26 at 1:30 PM revealed she was responsible for checking meal trays for accuracy for the lunch meal and she overlooked that Resident #10 did not get a double (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	portion of meat. A telephone interview with the Registered Dietitian (RD) on 01/22/26 at 10:48 AM revealed she suggested Resident #10 receive double portions because he experienced some weight loss after he was admitted and in November 2025, and the double portions seemed to help stabilize his weight. She stated a diet order of double portions meant the resident received double protein servings. The RD stated she expected residents to receive double portions as ordered. An interview with the Administrator on 01/23/26 at 10:01 AM revealed he expected residents to receive double portions as ordered. A telephone interview with the Medical Director on 01/23/26 at 2:02 PM revealed he expected residents to receive double portions as ordered. 2. Resident #2 was admitted to the facility on [DATE] with diagnoses that included diabetes and adult failure to thrive. The nutrition care plan last reviewed/revised on 10/01/25 revealed Resident #2 had a nutritional risk related in part to multiple comorbidities, abnormal nutrition-related lab values and need for a texture modified diet. Interventions included having the Registered Dietician (RD) evaluate and make diet changes as needed and serving Resident #2's diet as ordered. The quarterly Minimum Data Set (MDS) assessment dated [DATE] noted Resident #2 had moderate impairment in cognition and was dependent on staff assistance with eating. He received a mechanically altered diet and nutrition or hydration intervention to manage skin problems. A RD progress note dated 01/09/26 revealed Resident #2 had a current order for a mechanical soft diet with double protein portions and had end of life skin failure on the sacrum, left heel, right lateral midfoot, and right fifth toe. The RD noted Resident #2's current plan of care was ongoing, and the RD would follow-up as needed. Review of Resident #2's physician's orders revealed a diet order dated 01/17/25 for a mechanical soft diet with double protein portions. An observation of Resident #2's meal ticket on 01/22/26 at 12:48 PM revealed he was to receive a mechanical soft diet with double protein portions. An observation of Resident #2's meal tray at the same date and time revealed he received a chicken salad sandwich, a scoop of potato salad, a scoop of chopped broccoli salad, and mandarin oranges for dessert. The sandwich consisted of chicken salad placed between two slices of bread and was cut diagonally. The edges of all four sides of the slices of bread were touching, and the sandwich appeared uniformly thin without central bulging, indicating that Resident #2 did not receive a double protein portion. During an interview on 01/22/26 at 12:49 PM, Nurse Aide (NA) #1 confirmed she assisted Resident #2 with his lunch meal. NA #1 stated he received one chicken salad sandwich, but she could not state for certain if the sandwich had a double protein portion. During a phone interview on 01/23/26 at 11:35 AM, the RD stated Resident #2 was to receive double protein with his meals and when he was served a sandwich, it should contain double the meat. The RD stated the primary reason Resident #2 had a diet order to receive double protein portions was due to (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	end-of-life skin failure and she would expect for him to receive double protein portions with meals as ordered. During an interview on 01/23/26 at 1:21 PM, the Dietary Manager explained for residents with a diet order for double proteins, dietary staff were to use a #8 scoop, equivalent to 4 ounces. She explained that when properly portioned, the meat should prevent the bread slices from fully meeting at the edges and should be visible between the slices of bread when the sandwich was cut. The Dietary Manager reported that she was usually present on the tray line to ensure meals were being plated according to the meal ticket; however, she was not present on the tray line when Resident #2's lunch meal was prepared on 01/22/26. The Dietary Manager stated she would have expected for dietary staff to ensure Resident #2 received a double protein portion as ordered. During an interview on 01/23/26 at 2:02 PM, the Medical Director explained for wound healing, adequate protein intake was beneficial for wound healing, as it promoted granulation of tissue (new, connective tissue that develops from the base of a wound during the healing process). The Medical Director stated he would expect for residents to receive double protein portions if ordered. During an interview on 01/23/26 at 3:50 PM, the Administrator stated he would expect for diet orders to be followed, and residents received double protein portions as ordered.

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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.