STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. Building B. Wing	03/08/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 37280 Based on record reviews and staff interviews, the facility failed to ensure the code status information was accurate throughout the medical record for 3 of 19 residents (Resident #44, Resident #72 and Resident #140) reviewed for advanced directives. The findings included: a. Resident #44 was admitted to the facility on [DATE]. Review of the code status notebook that was maintained at the nursing desk revealed Resident #44 had a yellow Do Not Resuscitate (DNR) form dated [DATE] and an advanced directive for a Full Code signed on [DATE]. A review of Resident #44's electronic health record (EHR) on [DATE] at 2:16 PM revealed an order for a DNR dated [DATE]. The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #44's cognition was moderately impaired. b. Resident #72 was admitted to the facility on [DATE]. Review of the code status notebook that was maintained at the nursing desk. Resident #72 had a Do Not Resuscitate order for DNR dated [DATE] in the notebook. A review of Resident #72's electronic health record (EHR) on [DATE] at 2:33 PM revealed an order for Full Code dated [DATE]. The admission Minimum Data Set assessment dated [DATE] revealed the Resident's cognition was moderately impaired. c. Resident #140 was admitted to the facility on [DATE]. A review of the Nursing Admission assessment dated [DATE] revealed Resident #140 was alert and oriented to person, place, time and situation. (continued on next page)

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the code status notebook maintained at the nursing desk. Resident #140 had a Resuscitation order for Cardiopulmonary (CPR) signed by the Resident on [DATE]. Also, in the code status notebook was a pink Medical Order for Scope of Treatment (MOST) dated [DATE] signed by Resident #140. A review of Resident #140's electronic health record (EHR) on [DATE] at 2:07 PM revealed an order for a Full Code dated [DATE]. An interview was conducted with the Social Worker (SW) on [DATE] at 1:24 PM. The SW explained that she had been employed by the facility for 3 years and had a very limited role in the advanced directive process. She explained that when the resident was admitted to the facility, she checked the face sheet and whatever the advanced directive was determined which care plan she developed for the resident. The SW continued to explain that when a resident's advanced directive changed the nursing department informed her and she made the adjustment to the care plan. An interview was conducted with Unit Manager (UM) #1 on [DATE] at 1:34 PM. The UM explained that the two Unit Managers were responsible for admissions and double checked each other for orders that included the advanced directives. She continued to explain that after the resident was admitted they addressed the advanced directive with the resident or their representative and completed the facility's paperwork according to their desire. The UM stated after the completion of the paperwork they gave it to the Medical Records Director who placed it in the code status notebook at the nursing desk. The UM also indicated Medical Records was responsible for auditing the two records to ensure that they matched. On [DATE] at 2:13 PM during an interview with the Medical Records Director she explained that the Admissions Director of the Unit Managers were responsible for completing the advanced directive paperwork and then it was given to her to scan into the residents' medical records, and she would place it in the code status notebook at the nursing desk. She stated she audited the code status notebook every week, but she did not realize how often the code status changed and did not know that she was supposed to ensure the code status in the notebook matched the code status in the residents' medical record. During an interview with the Director of Nursing (DON) on [DATE] at 9:23 AM the DON explained that the unit managers were responsible for obtaining the advanced directives from the residents or their representatives after the residents were admitted and the Admissions Director was responsible for completing the paperwork. The DON indicated the Medical Records Director should be auditing the code status notebook but sometimes a nurse would be assigned to do it because of the frequent transfers to the hospital.

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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 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations, record review, and resident, staff, Police Officer, and Health Care Personnel Investigator interviews the facility failed to protect the resident's right to be free from misappropriation of resident property when Nurse Aide (NA) #1 allegedly stole a wallet and $320.00 from Resident #27. Resident #27 stated he felt like he was taken advantage of, and it really bothered him that she (NA #1) would do something like that. Resident #27 become tearful as he stated that he did not want this to happen to anyone else. This deficient practice affected 1 of 3 residents reviewed abuse, neglect, and misappropriation of resident property. The findings included: Resident #27 was readmitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #27 was cognitively intact, had no signs of delirium and no behaviors. An initial allegation report dated 12/14/23 read in part, Nurse Aide (NA) #1 had been accused of misappropriation of Resident #27's property. He stated that she came into his room late one evening and the next morning his wallet was missing from his locked drawer. NA #1 was suspended pending the investigation and Resident #27's belongings secured in a locked drawer and safe. Local law enforcement were notified. The report was signed by the former Administrator. The five working day report dated 12/21/23 indicated that Resident #27 identified NA #1 from the previous night as the accused individual. Local law enforcement through the magistrate office issued an arrest warrant and NA #1 was arrested for exploitation of elderly/handicap individual. NA #1 was accused of stealing $320. 00 and a $30.00 wallet. The allegation was substantiated, and NA #1 was terminated on 12/21/23. (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	An observation and interview were conducted with Resident #27 on 03/04/24 at 11:02 AM. Resident #27 was sitting up in his wheelchair and was noted to have a purple lanyard around his neck that had two keys on it. Resident #27 stated that he kept the key to the top nightstand drawer along with the key to his safe that sat on top of his nightstand on the lanyard around his neck. Resident #27 explained that on 12/13/23 NA #1 was in his room assisting his roommate and when she was done, she came to Resident #27's bedside and asked to borrow a dollar so she could get a snack. Resident #27 stated he told NA #1 he had snacks in his drawer, and she was welcome to them, but NA #1 was insistent that she wanted to borrow a dollar to get a snack out of the vending machine. Resident #27 stated that he handed NA #1 the key to the top drawer of his nightstand so that she could hand him his wallet and she did. Resident #27 explained that he kept both of his wallets in a black zipper pouch and in one wallet he kept dollar bills in and the other one he kept larger bills. After he had gotten the dollar bill out of his wallet, he put the wallet back in the black zipper pouch and handed it to NA #1 and asked her to please lock it back up in the top drawer of his nightstand. He added that NA #1 simulated putting the zipper pouch in the drawer and then emphasized to Resident #27 that she had locked the drawer and pulled on it to show that it was locked. Resident #27 stated that he never saw NA #1 put the zipper pouch/wallet in the drawer and the following morning when he got up, he went straight to the drawer and the zipper pouch/wallet was gone. Resident #27 explained that he was certain that it was NA #1 that took his wallet because that night he never went back to sleep and no one else came in his room that night. He added that another staff member had found the zipper pouch/wallet in another resident's room a week ago but the #320.00 cash was gone, his bank card and social security card were still in the wallet, but his cash was gone. Resident #27 explained that NA #1 had not been back into his room since this event and the only time he had seen her since 12/14/23 was when he went to court on two separate occasions for her hearing which was continued. He added he would be going back to court for a third time on 03/27/24. Resident #27 stated the on 12/14/23 he reported the incident to the former Administrator and since then he purchased a small safe to keep on top of his nightstand to keep his personal affects in. A follow up interview was conducted with Resident #27 on 03/06/24 at 9:38 AM. Resident #27 stated that having his money and wallet stolen made me feel like she took advantage of me. For a while I was very bothered by it because I thought she was an all-right girl. Resident #27 stated that the wallet was in a black zipper pouch and all the cash was gone except there was a secret compartment that NA #1 did not know about and there was 14.00 in there that she did not take but the other cash she took. He added that eventually the facility replaced his cash and now he kept his wallet in the safe that was purchased after the event. Resident #27 stated I have been to court 2 times, and I would rather be doing something else besides sitting in the court room. I have to go back to court again on 03/27/24. I feel like my things are safe here as long as they are locked up in my safe. Resident #27 became tearful and stated, thank you for looking into this I don't want this to happen to anyone else. An attempt to speak to NA #1 was made on 03/05/24 at 2:04 PM and was unsuccessful. (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	The former Administrator was interviewed via phone on 03/05/24 at 2:29 PM and again on 03/05/24 at 5:01 PM, he stated that on 12/14/23 he was notified that Resident #27 wanted to speak to him. He stated he spoke to Resident #27 who reported he thought that NA #1 had stolen his wallet during the night of 12/13/23. Resident #27 explained that NA #1 asked him to borrow a dollar and he had given her the key to his drawer to unlock it and hand him his wallet so he could give her a dollar and then he asked NA #1 to lock the wallet back up in the drawer, but he did not see her put the wallet in the drawer before she locked it. At the time he reported the incident to the former Administrator Resident #27 was able to describe NA #1, but she was working in the building that day and when NA #1 walked by Resident #27 he stated that is the girl that took my wallet. The Administrator stated that they immediately suspended NA #1 and began an investigation. The former Administrator stated at the end of the investigation they ended up terminating NA #1 in December 2023 based on the direct witness statement of Resident #27 and then a couple of days later we got notified that she (NA #1) had been arrested and charged. The Health Care Personnel Investigator (HCPI) was interviewed via phone on 03/05/24 at 4:06 PM, she stated that she was assigned the case involving NA #1 that allegedly occurred in the facility on 12/13/23. The Investigator further explained that NA #1 had outstanding criminal charges of misdemeanor larceny and exploitation of elderly person and was scheduled to be back in the court system on 03/27/24 and once the case was through the court system her registry information would be updated accordingly depending on the outcome of the case. She added that she had spoken to NA #1 via phone, and she denied the allegations and stated she had absolutely no reason why she was arrested and charged. The HCPI stated that the Director of Nursing (DON) had notified her that on 02/22/24 Resident #27's wallet had been found in another resident's room who spent all of her time in bed and was blind. She added that NA #1's case was still under investigation, and she was still attempting to speak to the Policer Officer that responded to the call on 12/14/23. NA #3 was interviewed on 03/06/24 at 9:58 AM, explained that on 02/22/24 she was working on Resident #27's unit and was making an incontinent round as usual. She stated she went into a female resident room to provide care to her, and her hearing device was squealing. The female resident's roommate stated that if the hearing device was squealing that meant the batteries were dead and her family had kept extra batteries in her nightstand. NA #3 stated she went ahead and provided care and got the resident situated and then opened her second drawer of her nightstand and there was a black zipper pouch. She stated she assumed that was where the extra batteries were kept and so she opened the black zipper pouch and when she opened it there was 2 wallets, one was green and black, and the other one was all black and when she opened the green and black one it had Resident #27's driver's license in it. NA #3 stated that she closed the wallet and put it back inside the zipper pouch and took it to the DON. (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	The Police Officer that responded to the facility on [DATE] was interviewed via phone on 03/08/24 at 5:39 PM. He stated that he responded to a call from the facility on 12/14/23 and when he arrived, he met with the former Administrator and then spoke to Resident #27. He stated that Resident #27 told him that NA #1 had asked him to borrow a dollar and he had given her the key to unlock his nightstand drawer and hand him his wallet and when he asked her to lock it back up, she had locked the drawer but he had not seen her put the wallet in the drawer before locking it and he was certain no one else had been in his room that night and the key remained on a lanyard around his neck. The Policer Officer stated that after he spoke to Resident #27, he had gone to the magistrate on Resident #27's behalf and had a probable cause hearing and warrant to continue investigating the case. He stated that a few days later NA #1 was arrested and charged with larceny and exploitation of an elderly person. The Police Officer stated that on 03/04/24 he had spoken at the grand jury hearing about NA #1 and the case was continued and she was due in court again on 03/27/24. He added that NA #1 still had 3 pending felony charges and 3 pending misdemeanor charges that she was being tried for. The DON was interviewed on 03/05/24 at 5:49 PM, she stated that on 12/14/23 Resident #27 reported to the former Administrator that he believed NA #1 had stolen his wallet during the night of 12/13/23 and so an investigation was started. The DON stated that the former Administrator handled most of the investigation, but she made sure Resident #27 was in court on both court dates. The DON explained that NA #1 was terminated in December 2023 because when they re-verified her nurse aide registry listing it came back with substantiated findings that occurred after she was hired, and she had not disclosed that to us. The DON also stated that on 02/22/24 NA #3 found Resident #27's zipper pouch/wallet in another resident room but his cash was gone. After the event on 12/13/23, the facility had interviewed the alert and oriented residents about exploitation and all staff were educated on the abuse, neglect, and misappropriation policy. In addition, the facility initiated a valuable sheet that was required to be filled out with 2 staff signatures and resident signature anytime a resident asked the staff to purchase something with their money. The plan was introduced into the quality assurance meeting on 12/19/23. Ongoing audits of the valuable sheets were done two times monthly until directed by the QA team. The facility provided the following corrective action plan with a completion date of 12/18/23. All items on this self-imposed plan have been implemented on 12/14/23 and completed on 12/18/23 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citation associated with this plan should be considered past noncompliance as of 12/18/23. Corrective action that will be accomplished: On 12/14/23 Administrator provided affected resident with a safe for valuable items. On 12/14/23 Administrator educated this resident (BIMS 14) on how to secure valuables/money in the lockable drawers in the nightstand in his room, in the Business office, and in the new safe. Identification of other residents: All residents who keep valuables/money are at risk of the same deficient practice. (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	Starting on 12/14/23, an audit was conducted by Administrator/designee where all residents with BIMS of 10 or greater were interviewed and questioned regarding exploitation and any concerns related to exploitation. Any concerns were addressed. Measures for system change: On or before 12/18/23, all staff were educated by the Administrator/all on abuse, neglect, and exploitation with an emphasis on exploitation and correct measures for interaction with residents related to money and valuables. On or before 12/18/23, all staff will be educated by the Administrator/designee on the new process that any staff member asked to assist any resident with money or valuable will be required to have a witness and complete an Audit sheet to any actions taken when it relates to resident's valuables/money. On or before 12/18/23, all residents with BIMS of 10 or greater were educated on how to secure valuables/money in the lockable drawer in the nightstand in their room or in the business office. How corrective action will be monitored: All activity with staff involvement related to valuables/money will be documented with signatures required by the resident, a staff member, a witness, and a Nurse Manager/Admin staff and returned to the Administrator or DON for record keeping purpose. This audit tool will be reviewed monthly x 2 months as part of QAPI process. The QAPI team will consider any changes to the process at that time. The corrective action plan was validated on 03/08/24. Resident #27 was verbally able to describe how and where he locked up his personal affects. Interviews with other alert and oriented residents also revealed that they were aware of how and where to lock up with personal affects. Staff interviews across all departments revealed that all staff were aware of the newly implemented process for handing resident money, and the requirement of having witness signatures and resident signatures and the need to turn them into the Administrator or DON. Initial audit of residents with BIMS of 10 or higher was reviewed and observations of resident's nightstand drawer with the lockable device were reviewed with no issues noted. The resident council was also educated on how and where to lock up their belongings and were educated on abuse, neglect, and exploitation. The plan went to the QA meeting on 12/19/23 and the ongoing audits of the valuable sheets were reviewed with no issues noted. The compliance date of 12/18/23 was validated.

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F 0606 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 35789 Based on record review, staff, and Health Care Personnel Investigator (HCPI) interviews the facility failed to terminate and allowed Nurse Aide (NA) #1 to continue to work after becoming aware that she had substantiated findings of misappropriation of resident property which occurred while NA #1 was employed in a nursing facility and had a substantiated finding of fraud against a resident which occurred while NA #1 was employed in a nursing facility on the North Carolina Nurse Aide Registry on 08/15/23. NA #1 was terminated on 12/21/23 following an investigation of misappropriation of Resident #27's property that allegedly occurred in the facility on 12/13/23. This deficient practice of allowing NA #1 to continue to work had the high likelihood to affect other residents. The findings included: Review of NA #1's employee file revealed she was hired by the facility on 03/09/23. The employee file had an Orientation Checklist that indicated a registry verification had been completed as well as her background check. The employee file contained no verification identification number (number you get when you verify a nurse aide registry listing). The file contained a background check that was completed on 03/10/23 and revealed no reportable court records found. Further review of NA #1's employee file revealed a North Carolina Nurse Aide 1 Registry verification completed on 08/15/23 with a confirmation number provided that indicated that NA #1 has 1 substantiated finding of Misappropriation of Resident Property which occurred while the individual was employed in a Nursing Facility. This information was entered on the Registry on 04/17/23. The verification further indicated that NA #1 has 1 substantiated finding of fraud against a resident which occurred while the individual was employed in a Nursing facility. This information was entered into the registry on 04/17/23. The former Human Resource Director was interviewed via phone on 03/05/24 at 4:26 PM, she explained that she worked for the company for a year and half. The former Human Resource Director stated that when she hired new Nurse Aides, she would always run their name and social security number through the Nurse Aide Registry system and then would enter their listing number and expiration date into the facility's onboarding system. She stated she did not retain the original verification, only entered the needed information into their onboarding system. She explained she was preparing to leave the facility to pursue other opportunities and that included uploading all the Nurse Aide information into the facility's electronic onboarding system and during that time she re-verified that all the Nurse Aide's registry information was valid. She stated that was when she discovered that NA #1 had findings of misappropriation and fraud on her registry listing, and she had not disclosed that information upon hire. The former Human Resource director stated that she had verified her registry listing information upon hire and there was nothing there and her background check was clean as well. She stated that after she made the discovery in August 2023, she took the information to the former Administrator who was also preparing to leave, and we sent the information to the Corporate Human Resource Director and also notified the District Director of Operations. She stated that NA #1 was terminated in December 2023 after an allegation of misappropriation of resident property but could not say what the outcome of reporting to the Corporate Human Resource Director and District Director of Operations was in August 2023. (continued on next page)

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F 0606 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The former Administrator was interviewed via phone on 03/05/24 at 2:29 PM and again on 03/05/24 at 5:01 PM, he stated that on 12/14/23 he was notified that Resident #27 wanted to speak to him. He stated he spoke to Resident #27 who reported he thought that NA #1 had stolen his wallet during the night of 12/13/23. Resident #27 explained that NA #1 asked him to borrow a dollar and he had given her the key to his drawer to unlock it and hand him his wallet so he could give her a dollar and then he asked NA #1 to lock the wallet back up in the drawer, but he did not see her put the wallet in the drawer before she locked it. At the time Resident #27 reported the incident to the former administrator he was able to describe NA #1, but she was working in the building that day and when NA #1 walked by Resident #27 he stated that is the girl that took my wallet. The Administrator stated that they immediately suspended NA #1 and began an investigation. The former Administrator stated at the end of the investigation they ended up terminating NA #1 in December 2023 based on the direct witness statement of Resident #27 and then a couple of days later the former Administrator got notified that she had been charged and arrested. The former Administrator stated that he was only notified of NA #1's registry findings during the investigation of Resident #27's missing wallet and money, he stated had he known earlier about the finding's that were on NA #1's registry listing they would have immediately separated employment with NA #1. He further added that he recalled that the registry listing that he was aware of was not a conviction but was listed as a pending charge or an accusation. The District Director of Operations was interviewed via phone on 03/05/24 at 4:51PM, he stated that he was aware of the situation with NA #1. He stated he could not speak to the timing of the discovery but what he recalled was that during the investigation of Resident #27's missing wallet and money they re-verified NA#1's registry listing which was part of their routine practice and discovered that after she was hired, she had something on her registry listing. When they discovered that NA #1 had something on her registry listing, he had the staff re-verify everyone to ensure that no one else had anything on their registry listing. The District Director of Operations stated that the former Human Resource director never shared with him the Nurse Aide registry findings in August 2023, or he would have separated employment with NA #1 at that time. The Corporate Human Resource Director was interviewed via phone on 03/06/24 at 10:53 AM, she stated that she had not started with the company until September 2023 and was not aware of registry findings for NA #1 until December 2023 when she was terminated from the company. She confirmed that if anything came back on the NA registry, the information would be shared with her and the decision would made to separate employment and if the findings had anything to do with a resident in a nursing facility it would be grounds for immediate termination. The Health Care Personnel Investigator (HCPI) was interviewed via phone on 03/05/24 at 4:06 PM, she stated that she was assigned the case involving NA #1 that allegedly occurred in the facility on 12/13/23. She explained that NA #1 had another case involving misappropriation of resident property and fraud against a resident that was opened on 11/15/22 and the decision to substantiate was made on 03/01/23. At the time that decision was made the North Carolina Nurse Aide Registry would have been updated to reflect those findings. She continued to say that if the facility had verified NA #1's registry listing on 03/09/23 which was her date of hire the findings of misappropriation and fraud against a resident would have been pending but would have been present on her registry verification and the facility should not have hired her. Once the appeal process was over the pending findings would have been changed to substantiated, which they did so on 04/17/23. The HCPI further explained that NA #1 had outstanding criminal charges of misdemeanor larceny and exploitation of elderly person and was scheduled to be back in the court system on 03/27/24 and once the case was through the court system her registry information would be updated accordingly depending on the outcome of the case. (continued on next page)

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F 0606 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Director of Nursing (DON) was interviewed on 03/05/24 at 5:49 PM, she stated that on 12/14/23 Resident #27 reported to the former Administrator that he believed NA #1 had stolen his wallet during the night of 12/13/23 and so an investigation was started. The DON stated that when NA #1 was hired they verified her registry listing and there was nothing on it but during the investigation of Resident #27's missing wallet and money they re-verified her registry listing and found that she had something on her registry listing. The DON stated that if that came up after we hired NA #1, she felt like she (NA #1) should have disclosed that information to us and that was why we terminated her in December 2023. The DON stated that the former Administrator handled most of the investigation, but she made sure Resident #27 was in court on both court dates. She stated that she was unaware of the registry listing that was pulled in August 2023 and that had she known she would have immediately separated employment with NA #1. The Administrator and DON were notified of immediate jeopardy on 03/06/24. The facility provided the following corrective action plan with a completion date of 12/22/23: All licensed staff and certified staff were re-verified through NC Nurse Aid Registry and NC Board of Nursing Registry for any substantiated findings for any abuse/misappropriation, by the Director of Nursing. Completed on 12/21/23 Identification of other Residents: No other staff were identified with negative findings on the re-verification (re-verification was completed by the Director of Nursing running the licensure/certification off the nurse aid registry and the Board of Nursing registry) Measures for Systemic Change: All new hires will be verified to ensure no substantiated findings on their license/ certification for abuse/misappropriation, by the Human Resource (HR) Director or Director of Nursing prior to employment, upon renewal of licensure/certification and prn with allegations, any negative findings will be brought to the Administrator and Director of Nursing to review. HR Director receives a report monthly with upcoming license and certification renewals. If any substantiated findings are noted the HR Director will notify Administrator and Corporate HR for direction related to the employee's employment. HR Director was informed of this requirement and process by the Administrator on 12/20/23. How Corrective Action will be Monitored: On 12/20/23 monitoring of this process was implemented following review by QA on 12/19/23. HR Director or Director of Nursing will run reports from NC Nurse Aid registry and NC Board of Nursing Registry for all licensed and certified staff monthly X 6 months, and randomly thereafter to ensure that no staff have substantiated findings on their records. All new hires will be verified by HR Director or Director of Nursing prior to employment, upon renewal and prn with any allegations. The Administrator and/or Director of Nursing will review the reports for compliance. Results of these audits will be reviewed in the monthly Quality Assurance and Performance Improvement Committee meeting with the QAPI Committee responsible for ongoing compliance. (continued on next page)

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	345080	A. Building B. Wing	03/08/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0606 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Date of compliance: 12/22/23 The corrective action plan was validated on 03/08/24. The verification of all Nurse Aide registry listing information and Board of Nursing verification were reviewed with no other issues noted. All newly hired nurse aide and nurses since 12/22/23 have been verified through either the Nurse Aide registry or Board of Nursing and those verifications were reviewed with no further issues noted. The facility had no allegations of abuse, neglect, or misappropriation of resident property since 12/22/23. The facility has re-verified all nurse aide listings and nursing license for staff monthly since 12/22/23, those were reviewed with no negative findings noted. Interviews with the Human Resource director and administrative staff revealed that they were aware that all nurse aide registry and nursing license were to be verified monthly, with renewal, and with any allegation of abuse, neglect, or misappropriation of resident property that the employee was involved with. The corrective action plan was taken to the Quality Assurance meeting on 12/19/23. The facility's compliance date of 12/22/23 was validated.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 35789 Based on record review and staff interviews the facility failed to implement their abuse policy by failing to separate employment of Nurse Aide (NA) #1 on 08/15/23 when the facility became aware that she had substantiated findings of misappropriation of resident property and fraud against a resident that occurred while the individual was employed in a nursing facility. NA #1 continued her employment with the facility until 12/21/23 when she was terminated following an allegation of misappropriation of resident property. This deficient practice affected 1 of 3 residents (Resident #27) reviewed for abuse, neglect, and misappropriation of resident property and had the high likelihood to affect other residents in the facility. The census at the time of the survey was 86 residents. The findings include: Review of a facility policy titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated 03/28/23 read in part, Conduct employee background checks and not knowingly employ or otherwise engage any individual who has: been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law, had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of their property, or a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property. Review of NA #1's employee file revealed she was hired by the facility on 03/09/23. The employee file had an Orientation Checklist that indicated a registry verification had been completed as well as her background check. The orientation checklist had been completed by the former Human Resource Director. The employee file contained no verification identification number (number you get when you verify a nurse aide registry listing). The file contained a background check that was completed on 03/10/23 and revealed no reportable court records found. Further review of NA #1's employee file revealed a North Carolina Nurse Aide I Registry verification completed on 08/15/23 with a confirmation number provided that indicated that NA #1 has 1 substantiated finding of Misappropriation of Resident Property which occurred while the individual was employed in a Nursing Facility. This information was entered on the Registry on 04/17/23. The verification further indicated that NA #1 has 1 substantiated finding of fraud against a resident which occurred while the individual was employed in a Nursing facility. This information was entered into the registry on 04/17/23. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The former Human Resource Director was interviewed via phone on 03/05/24 at 4:26 PM. The former Human Resource Director stated that when she hired new Nurse Aides, she would always run their name and social security number through the Nurse Aide Registry system and then would enter their listing number and expiration date into the facility's onboarding system. She stated she did not retain the original verification, only entered the needed information into their onboarding system. She explained that she was preparing to leave the facility to pursue other opportunities and part of preparing to leave the facility included uploading all the Nurse Aide information into the facility's electronic onboarding system and during that time she re-verified that all the Nurse Aide's registry information was valid. She stated that was when she discovered that NA #1 had findings of misappropriation and fraud on her registry listing, and she had not disclosed that information upon hire. The former Human Resource director stated that she had verified her registry listing information upon hire and there was nothing there and her background check was clean as well. She stated that after she made the discovery in August 2023, she took the information to the former Administrator who was also preparing to leave, and the information was sent to the Corporate Human Resource Director and also notified the District Director of Operations. She stated that NA #1 was terminated in December 2023 after an allegation of misappropriation of resident property but could not say what the outcome of reporting to the Corporate Human Resource Director and District Director of Operations was in August 2023. An initial allegation report dated 12/14/23 read in part, Nurse Aide (NA) #1 had been accused of misappropriation of Resident #27's property. He stated that she came into his room late one evening and the next morning his wallet was missing from his locked drawer. NA #1 was suspended pending the investigation and Resident #27's belongings secured in a locked drawer and safe. Local law enforcement were notified. The report was signed by the former Administrator. The five working day report dated 12/21/23 indicated that Resident #27 identified NA #1 from the previous night as the accused individual. Local law enforcement through the magistrate office issued an arrest warrant and NA #1 was arrested for exploitation of elderly/handicap individual. NA #1 was accused of stealing $320. 00 and a $30.00 wallet. The allegation was substantiated, and NA #1 was terminated on 12/21/23. The former Administrator was interviewed via phone on 03/05/24 at 2:29 PM and again on 03/05/24 at 5:01 PM, he stated that on 12/14/23 he was notified that Resident #27 wanted to speak to him. He stated he spoke to Resident #27 who reported he thought that NA #1 had stolen his wallet during the night of 12/13/23. Resident #27 explained that NA #1 asked him to borrow a dollar and he had given her the key to his drawer to unlock it and hand him his wallet so he could give her a dollar and then he asked NA #1 to lock the wallet back up in the drawer, but he did not see her put the wallet in the drawer before she locked it. At the time Resident #27 reported the incident to the former administrator he was able to describe NA #1, but she was working in the building that day and when NA #1 walked by Resident #27 he stated that is the girl that took my wallet. The Administrator stated that they immediately suspended NA #1 and began an investigation. The former Administrator stated at the end of the investigation they ended up terminating NA #1 in December 2023 based on the direct witness statement of Resident #27 and then a couple of days later the former Administrator got notified that she had been charged and arrested. The former Administrator stated that he was only notified of NA #1's registry findings during the investigation of Resident #27's missing wallet and money, he stated had he known earlier about the finding that were on NA #1's registry listing they would have immediately separated employment with NA #1 per the facility policy. He further added that he recalled that the registry listing that he was aware of was not a conviction but was listed as a pending charge or an accusation. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The District Director of Operations was interviewed via phone on 03/05/24 at 4:51PM, he stated that he was aware of the situation with NA #1. He stated he could not speak to the timing of the discovery but what he recalled was that during the investigation of Resident #27's missing wallet and money they re-verified NA#1's registry listing which was part of their routine practice and discovered that after she was hired, she had something on her registry listing. When they discovered that NA #1 had something on her registry listing, he had the staff re-verify everyone to ensure that no one else had anything on their registry listing. The District Director of Operations stated that the former Human Resource director never shared with him that registry findings in August 2023 or he would have separated employment with NA #1 at that time per their facility policy. The Corporate Human Resource Director was interviewed via phone on 03/06/24 at 10:53 AM, she stated that she had not started with the company until September 2023 and was not aware of registry findings for NA #1 until December 2023 when she was terminated from the company. She confirmed that if anything came back on the NA registry the information would be shared with her and the decision would made to separate employment and if the findings had anything to do with a resident in a nursing facility it would be grounds for immediate termination per their policy. The Director of Nursing (DON) was interviewed on 03/05/24 at 5:49 PM, she stated that on 12/14/23 Resident #27 reported to the former Administrator that he believed NA #1 had stolen his wallet during the night of 12/13/23 and so an investigation was started. The DON stated that when NA #1 was hired they verified her registry listing and there was nothing on it but during the investigation of Resident #27's missing wallet and money they re-verified her registry listing and found that she had something on her registry listing. The DON stated that if that came up after we hired NA #1, she felt like she (NA #1) should have disclosed that information to us and that was why we terminated her in December 2023. The DON stated that the former Administrator handled most of the investigation, but she made sure Resident #27 was in court on both court dates. She stated that she was unaware of the registry listing that was pulled in August 2023 and that had she known she would have immediately separated employment with NA #1 per their policy. The Administrator and DON were notified of Immediate jeopardy on 03/06/24 1:08 PM. The facility provided the following corrective action plan with a completion date of 12/22/23: F607 Failure to Implement Abuse policy. CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED: On 12/20/2023, The Facility Administrator was notified by The Human Resources Director of adverse action on North Carolina Nurse Aide Registry for an employee suspended on 12/14/2023. On 12/20/2023, The Facility Administrator addressed the failure to follow abuse policy by providing education to The Human Resource Director on the abuse policy and following the process for monitoring the NC Nurse Aid Registry and the NC Board of Nursing Registry to ensure no adverse action noted on staff members licenses/certifications. On 12/21/2023, the employee with adverse findings was terminated from the facility by Director of Nursing. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	IDENTIFICATION OF OTHER RESIDENTS: All residents have the potential to be affected. On 12/21/23, all current licensed and certified facility staff were re-verified through North Carolina Nurse Aide Registry (NCNAR) and NC Board of Nursing Registry for any adverse finding or action by the DON with no additional employees noted with adverse actions. No other negative findings noted. MEASURES FOR SYSTEMIC CHANGE: In addition to pre-hire verification, licensed and certified employees will be verified by the Human Resources director or the DON against the NCNAR and NC Board of Nursing Registry upon license or certification renewal, and in the event of an abuse allegation. Facility administrator educated human resource director to this process on 12/20/2023. Human Resource director and director of nursing receive monthly reports of upcoming license and certification renewals. Abuse allegations involving facility staff are communicated to human resources by administrator or director of nursing. On 12/20/2023 The Human Resources Manager was made aware of this monitoring process by the Facility Administrator. A new HR Manager was hired on 1/3/2024 and was educated on this process by the Corporate HR Director. On 12/21/2023, enhanced education was added by the corporate Human Resources director to new hire orientation for any new human resources employees regarding policy and notification of any adverse findings on NCNAR checks and NC Board of Nursing Registry. HOW CORRECTIVE ACTION WILL BE MONITORED: As of 12/21/2023, The Human Resource Manager or Director of Nursing will run reports from the NC Nurse Aid Registry and the NC Board of Nursing Registry for all licensed and certified staff monthly to ensure that no staff have substantiated findings on their records. On 12/20/2023 monitoring of this process was implemented following review by QA on 12/19/23. The Administrator and/or Director of Nursing will review the reports for compliance. Results of these audits will be reviewed in the monthly Quality Assurance and Performance Improvement Committee meeting with the QAPI Committee responsible for ongoing compliance. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. Date of Compliance 12/22/2023 (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The corrective action plan was validated on 03/08/24. The verification of all nurse aide registry listing information and Board of Nursing verification were reviewed with no other issues noted. All newly hired nurse aide and nurses since 12/22/23 have been verified through either the nurse aide registry or Board of Nursing and those verifications were reviewed with no further issues noted. The facility had no allegations of abuse, neglect, or misappropriation of resident property since 12/22/23. The facility had re-verified all nurse aide listings and nursing license for staff monthly since 12/22/23, those were reviewed with no negative findings noted. Interviews with the Human Resource director and administrative staff revealed that they were aware that all nurse aide registry and nursing license were to be verified monthly, with renewal, and with any allegation of abuse, neglect, or misappropriation of resident property that the employee was involved with. The corrective action plan was taken to the Quality Assurance meeting on 12/19/23. The facility's compliance date of 12/22/23 was validated.