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	08/17/2023

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations and staff interviews the facility failed to maintain a safe homelike environment when an electrical outlet was not secured to the wall (room [ROOM NUMBER]) and failed clean side rails on resident beds (room [ROOM NUMBER] B, room [ROOM NUMBER] A, room [ROOM NUMBER] A, and room [ROOM NUMBER] B) this affected 1 of 4 units in the facility (North). The findings included: 1. An observation of room [ROOM NUMBER] A on the North unit was made on 08/14/23 at 10:37 AM. The electrical outlet behind the resident bed was noted to be unsecured to the wall in which it was placed. The outlet had been placed inside the dry wall and a bit of caulk (flexible material used to seal cracks and gaps) had halfway been applied. The open wall space behind the outlet was visible. There was medical equipment plugged into the outlet. An observation of room [ROOM NUMBER] A on the North unit was made on 08/15/23 at 9:07 AM. The electrical outlet behind the resident bed was noted to be unsecured to the wall in which it was placed. The outlet had been placed inside the dry wall and a bit of caulk had halfway been applied. The open wall space behind the outlet was visible. There was medical equipment plugged into the outlet. An observation of room [ROOM NUMBER] A on the North Unit was made on 08/16/23 at 8:38 AM. The electrical outlet behind the resident bed was noted to be unsecured to the wall in which it was placed. The outlet had been placed inside the dry wall and a bit of caulk had halfway been applied. The open wall space behind the outlet was visible. There was medical equipment plugged into the outlet. The Maintenance Assistant was interviewed on 08/16/23 at 9:45 AM who confirmed that he was covering for the Maintenance Director who was out of work. He stated that anytime that there was a needed repair within the facility the staff (any staff) would fill out a repair slip and place it in the book at the nurse's station. Each morning the Maintenance Assistant stated he would check the book and make any needed repairs. The Maintenance Assistance accompanied the State Surveyor to room [ROOM NUMBER] A on the North unit to observe the electrical outlet behind the resident bed. The Maintenance Assistant confirmed that no one had reported the outlet to him, and he was unaware of the condition of the outlet. He stated that it did not look very safe, and he would repair it immediately. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 08/17/23 at 11:08 AM and was made aware of the condition of the electrical outlet. Her only response was that the Maintenance Assistant had changed it right away. 2a. Observations of Room # 103 B on the North unit were made on 08/14/23 at 9:49 AM, 08/15/23 at 8:45 AM, and 08/16/23 at 8:34 AM. The inside corner of the side rails on the occupied resident bed were noted to be full of food crumbs, dirt, and debris. The left side rail contained more crumbs, dirt, and debris than the right-side rail contained. b. Observations of room [ROOM NUMBER] A on the North unit were made on 08/14/23 at 10:15 AM, 08/15/23 at 8:47 AM, and 08/16/23 at 8:22 AM. The side rails on the occupied resident bed were full of food crumbs, dirt, and debris. The right-side rail contained more crumbs, dirt, and debris than did the left side rail. c. Observations of room [ROOM NUMBER] A on the North unit were made on 08/14/23 at 11:33 AM, 08/15/23 at 9:08 AM, and 08/16/23 at 8:34 AM. The side rails on the occupied resident bed were full of food crumbs, dirt, and debris. The right-side rail contained more crumbs, dirt, and debris than did the left side rail. d. Observations of room [ROOM NUMBER] B on the North unit were made on 08/14/23 at 2:18 PM and 08/16/23 at 8:40 AM. The side rails on the occupied resident bed were full of food crumbs, dirt, and debris. An interview was conducted with Housekeeper #1 on 08/16/23 at 9:00 AM who confirmed that she worked on North unit. She stated each morning she reported to work she would go to her assigned resident rooms and empty the trash, dust the rooms, and make sure all high touch surfaces were cleaned and sanitized before cleaning the bathroom. Once the resident room and bathroom were cleaned Housekeeper #1 stated she would sweep and mop the room before moving to the next resident room. Housekeeper #1 stated that side rails were a high touch surface area, and they were cleaned with a disinfectant cleaner on a daily basis and of course as needed. Housekeeper #2 was interviewed on 08/16/23 at 9:04 AM who confirmed that she worked North unit anytime she was assigned to do so. She stated that each resident room was cleaned daily including weekends. She stated that first she would empty the trash can in the resident room before wiping down the bed side tables and other high touch surfaces and before she left, she would sweep and mop the floor. Housekeeper #2 confirmed that resident side rails were high touch surface areas and those were cleaned on a daily basis. The Director of Housekeeping was interviewed on 08/16/23 at 9:10 AM who confirmed that Housekeepers #1 and #2 were responsible for cleaning resident rooms on a daily basis. He stated that he checked behind the housekeepers and graded the cleanliness of their assigned rooms as way of ensuring they were doing what was expected of them. The Director of Housekeeping accompanied the State Surveyor to Room # 103 B, room [ROOM NUMBER] A, room [ROOM NUMBER] A, and room [ROOM NUMBER] B and agreed that the residents side rails were full of food crumbs, dirt, and debris and stated that he would take care of it immediately. The Administrator was interviewed on 08/17/23 at 11:08 AM and indicated she was aware of the resident side rails but declined to further comment on the subject.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations, record review, staff, resident, and Physician Assistant interviews the facility failed to ensure a Bilevel Positive airway Pressure (BiPAP) machine (machine used to push air into your lungs), was in working order (Resident #38), failed to ensure oxygen concentrators and filters were clean (Resident #6, Resident #9, Resident #18, and Resident #65), failed to ensure an oxygen concentrator had external filters (Resident #21), and failed to ensure an oxygen flow rate was at the prescribed rate (Resident #6). This affected 6 of 6 residents reviewed for respiratory care. The findings included: 1. Resident #38 was admitted to the facility on [DATE] and most recently readmitted on [DATE]. Resident #38's diagnoses included chronic obstructive pulmonary disease, acute/chronic respiratory failure with hypoxia, and others. Review of a physician order dated 07/31/23 read, BiPaP machine at night. Inspiratory pressure 12, Expiratory Pressure 6, and timed rate 14 with 3 liters of oxygen for chronic obstructive pulmonary disease. Review of the Treatment Administration Record (TAR) dated 08/01/23 through 08/31/23 revealed that Resident #38 wore her BiPaP nightly as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #38 was cognitively intact and required oxygen during the assessment reference period. An interview and observation were conducted with Resident #38 on 08/14/23 at 9:45 AM. Resident #38 was resting in bed with an oxygen cannula in her nose at 3 liters per minute. Resident #38 stated she recently returned to the facility from the hospital and had a new BiPaP machine that she wore each night. She stated that last night the BiPaP machine did not work, and she did not sleep most of the night because her machine was not working. She stated that Nurse #1 had tried to get it working but could not. Resident #38 was in no respiratory distress. An interview and observation were conducted with Resident #38 on 08/15/23 at 8:46 AM. Resident #38 was resting in bed and had an oxygen cannula in her nose at 3 liters per minute. She stated that she could not use her BiPaP machine last night because it was still not working. She stated she had slept a bit but not for long and it certainly was not good sleep. Resident #38 was in no respiratory distress. An interview and observation were conducted with Resident #38 on 08/16/23 at 8:46 AM. Resident #38 was resting in bed and had oxygen in use at 3 liters per minute. She stated that her BiPaP machine did not work again last night, and she was not sure who the nurse was, but she tried to get it to come on but couldn't. Attempts to speak to Medication Aide (MA) #1 were made on 08/16/23 at 9:58 AM and were unsuccessful. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with MA #2 on 08/16/23 at 11:07 AM. MA #2 confirmed that she was caring for Resident #38 and that she had relieved MA #1 this morning. During report MA #2 stated that MA #1 did not report anything to her about Resident #38's BiPaP machine not working. If he had reported that, MA #2 stated she would report that to her nurse immediately so they could get it repaired. MA #2 confirmed that when she arrived for her shift, Resident #38 did not have her BiPaP machine on but did have her oxygen on. Nurse #2 was interviewed on 08/16/23 at 12:01 PM who confirmed that she had worked second shift with Resident #38 the previous day. Nurse #2 stated she was not aware that Resident #38's BiPaP machine was not working until earlier on 08/16/23 when MA #2 had reported it to her. She stated she was busy and asked MA #2 to alert the Unit Manager (UM) about the BiPaP machine that was not working. The Physician Assistant (PA) was interviewed via phone on 08/16/23 at 2:35 PM. The PA stated that BiPaP machines should be worn each night and if the resident did not wear it every night, they may wake up with a headache and feel exhausted. She explained that if the resident's oxygen level dropped through the night and they did not have their BiPaP machine on the resident would not be getting enough oxygen to the brain which would lead to the headache and fatigue the next day. The UM was interviewed on 08/16/23 at 3:53 PM who confirmed that MA #2 had reported to her earlier that day that Resident #38's BiPaP machine was not working, and she had called the rental company and they were going to send her another machine immediately. The UM stated she had gone down to speak to Resident #38, and she reported that it had not been working for a couple of days. The UM again confirmed that she was unaware of the BiPaP machine not working until early during her shift on 08/16/23. Nurse #1 was interviewed on 08/17/23 at 6:56 AM and confirmed that he had worked with Resident #38 on 08/14/23. Nurse #1 stated that around 2:00 AM on 08/14/23 Resident #38 called Nurse #1 to her room and reported her BiPaP machine was not working. Nurse #1 stated he could not get the machine to work properly even after resetting it several times, so he gave Resident #38 a breathing treatment, checked her oxygen saturation level, and made sure her oxygen was in place at 3 liters. Nurse #1 also stated that he looked for a manual for the machine but could not locate one. Nurse #1 thought that he had reported the BiPaP machine to Nurse #4 on Tuesday morning during report. He added that Nurse #2 was on duty on second shift Monday night, and she may have been aware of the BiPaP machine that was not working as well. Nurse #4 was interviewed on 08/17/23 at 9:11 AM who stated that she was the nurse responsible for Resident #38 earlier in the week. She stated she was not aware that Resident #38's BiPaP machine was not working. She confirmed that Nurse #1 nor MA #1 reported any issues to her regarding the BiPaP machine. If she had been aware she would have let the UM know so that someone could have come and repaired the machine. An interview and observation were conducted with Resident #38 on 08/17/23 at 9:14 AM who reported that she did not wear her BiPaP machine last night because it was still not working properly. She stated the staff had told her they were sending her a new one, but she was not sure when it would arrive. Resident #38 was in no respiratory distress. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing (DON) was interviewed no 08/17/23 at 10:32 AM. The DON stated she was on vacation 08/14/23 and 08/15/23 and returned to the facility on [DATE] and was informed that Resident #38's BiPaP machine was not working. She stated she went and looked at the machine and it appeared the start/stop button had stopped working, she stated that she got the machine to come on using the auto on feature that the machine had but then it could not be turned off unless you unplugged the machine. The DON stated that they had contacted the rental company and they were going to send a replacement to the facility for Resident #38. 2. Resident #6 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, acute/chronic respiratory failure, and others. Review of a physician order dated 04/22/21 read; oxygen at 3 liters continuous via nasal cannula to maintain oxygen saturation levels above 90%. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #6 was cognitively intact and required oxygen use during the assessment reference period. No shortness of breath was noted during the look back period. Review of Resident #6's medical record revealed her oxygen saturation range for August 2023 was 90-95% except on 08/15/23 Resident #6's oxygen saturation level was 88%. An observation and interview were conducted with Resident #6 on 08/14/23 at 11:51 AM. Resident #6 was resting in bed with oxygen in use at 1 liter per minute via nasal cannula. Her oxygen concentrator was sitting in a corner or her room out of Resident #6's reach. Resident #6 was in no respiratory distress but stated she thought she was supposed to be on 2 liters of oxygen. Resident #6 stated she felt like she needed to be on 2 liters of oxygen, and she would have the staff fix the concentrator when they came back into the room. Resident #6's oxygen concentrator had 2 external filters one on each side of the concentrator. Both external filters were supposed to be black in color but were white due to the dust that covered each of them. An observation and interview were conducted with Resident #6 on 08/15/23 at 9:08 AM. Resident #6 was resting in bed with oxygen in use at 1 liter via nasal cannula. She stated that she had forgotten to say anything to the nursing staff about her oxygen but felt better today. Both external filters of the oxygen concentrator were supposed to be black in color but were white due to the dust that covered each of them. Resident #6 was in no respiratory distress. An interview was conducted with Nurse #4 on 08/15/23 at 2:53 PM who confirmed that she was caring for Resident #6. Nurse #4 stated that Resident #6 was supposed to be on 2 liters of oxygen and that she generally checked the flow rate at least once every day during her shift. Nurse #4 stated that the oxygen concentrators did not have filters that would requiring cleaning or changing. Nurse #4 was asked to accompany the State Surveyor to Resident #6's room. She confirmed that Resident #6's oxygen level was at 1 liter per minute and bumped it to 2 liters per minute. Nurse #4 was also shown both external filters of the oxygen concentrator and agreed that the filters were dirty with dust and needed to be cleaned. Nurse #4 stated she would take care of them immediately. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of Resident #6 was made on 08/17/23 at 10:15 AM. Resident #6 was resting in bed with her eyes closed and had oxygen in use at 2 liters per minute via nasal cannula. Both external filters of the oxygen concentrator had been cleaned and where black in color with no dust noted on either of them. The Director of Nursing (DON) was interviewed on 08/17/23 at 10:32 AM. The DON stated that the oxygen flow rate should be checked at least every shift and when switching a resident between a concentrator and a e-tank (portable tank of oxygen), to ensure the correct flow rate. She was made aware of Resident #6's oxygen flow rate and her oxygen saturation level of 88% on 08/15/23 and stated she would speak to the medical provider for guidance regarding Resident #6's oxygen level. The DON stated that the oxygen filters were scheduled to be cleaned or changed once a month and when visibly soiled. The DON stated that the facility may need to adjust the frequency of the cleaning of oxygen filters so that the dust did not build up. She stated that the facility had recently been undergoing some renovations and believed that the increase in dust particles came from that construction. 3. Resident #9 was admitted to the facility on [DATE] and most recently readmitted to the facility on [DATE]. Resident #9's diagnoses included chronic obstructive pulmonary disease, obstructive sleep apnea, acute respiratory failure, and others. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #9 was cognitively intact and required oxygen use during the assessment reference period. An observation of Resident #9 was made on 08/14/23 at 10:32 AM. Resident #9 was resting in bed and had oxygen in use. Resident #9's oxygen concentrator was sitting next to her bed and there was no external filter noted on the machine. The oxygen concentrator was observed to have large clumps of dust and debris seeping out of the seam of the machine where the two side of the concentrator came together. The side handles of the concentrator were covered with white dust particles and the machine itself was covered with dirt and grim. Resident #9 stated she could not remember the last time she had seen the staff clean her oxygen concentrator. An observation of Resident #9 was made on 08/15/23 at 8:53 AM. Resident #9 was resting in bed and had oxygen in use. Resident #9's oxygen concentrator was sitting next to her bed and there was no external filter noted on the machine. The oxygen concentrator was observed to have large clumps of dust and debris seeping out of the seam of the machine where the two side of the concentrator came together. The side handles of the concentrator were covered with white dust particles and the machine itself was covered with dirt and grim. An interview with Nurse #4 was conducted on 08/15/23 at 2:53 PM who confirmed that she was responsible for Resident #9. Nurse #4 was asked to accompany the State Surveyor to Resident #9's room to observe the oxygen concentrator. Nurse #4 stated that she had observed Resident #9's flow rate but had not paid attention to the concentrator itself. Nurse #4 agreed the concentrator was dirty and contained dust buildup. She stated that she was going to see if maintenance could get Resident #9 a new oxygen concentrator. An observation was made on 08/16/23 at 9:54 AM. The maintenance staff was observed delivering a new oxygen concentrator to Resident #9. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing (DON) was interviewed on 08/17/23 at 10:32 AM. The DON stated that she had just returned from vacation and about a week prior to her vacation she had spoken to the Respiratory Therapist (RT) about having the internal oxygen concentrator filters cleaned. She explained that the facility had recently undergone renovations and she believed that the increase in dust particles came from the renovations. The DON added that normally the internal oxygen concentrator filters were cleaned annually but she had requested for them to be done sooner due to the renovations and increase in dust particles. 37280 4. Resident #18 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD). A review of Resident #18's care plan revised 01/20/17 indicated the use of oxygen related to the diagnosis of COPD with the goal that the Resident would have no signs or symptoms of poor oxygenation. The interventions utilized included administering supplemental oxygen at the prescribed rate and monitor for symptoms of poor oxygenation. A review of Resident #18's physician order dated 01/28/21 indicated check and clean concentrator filter every month and PRN (as needed) every night shift starting on the 28th and ending on the 28th every month. A review of Resident #18's physician order revised 06/03/23 indicated continuous oxygen at 2-6 liters per minute via nasal cannula to maintain oxygen saturation greater than 88%. Resident #18's quarterly Minimum Data Set assessment dated [DATE] indicated the Resident was cognitively intact and received supplemental oxygen therapy. A review of Resident #18's July 2023, Treatment Administration Record (TAR) revealed on 07/28/23 the TAR was initialed by Nurse #3. An interview and observation were conducted with Resident #18 on 08/14/23 at 9:21 AM. The Resident wore oxygen via nasal cannula and explained that she wore the oxygen continuously. The oxygen concentrator had a black filter attached to the back of the concentrator which had a thick accumulation of dust that the filter appeared gray. An observation of Resident #18's oxygen concentrator filter on 08/15/23 at 8:43 AM remained unchanged with the black imprint still in the filter. On 08/15/23 at 2:24 PM an interview was conducted with Nurse #4 who confirmed that she was the full time Nurse on Resident #18's hall. The Nurse explained that the oxygen filters were cleaned every week or two by the housekeeping department because they had the stuff used to clean the filters. The Nurse stated if the filters were dusty then they needed to be changed because they would stop up. During the interview, the Nurse observed the dusty gray filter on the back of Resident #18's concentrator and remarked that she needed to go get some supplies and clean the filter. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Unit Manager (UM) on 08/15/23 at 3:03 PM explained the oxygen concentrator filters were checked and cleaned monthly on the 15th by the third shift nurse. The UM stated her expectation was that the filters be cleaned more often because since the facility recently had remodeling, there had been more dust and the filters should be cleaned as needed. An interview was conducted with Nurse #3 on 08/15/23 at 10:12 PM who initialed that she checked and cleaned Resident #18's oxygen filter on 07/28/23. The Nurse explained that the oxygen concentrators were cleaned once a month and the schedule would be on the TAR. The Nurse stated she did not remember when she cleaned the Resident's filter last but if her initials were on the TAR then she cleaned the filter. During an interview with the Director of Nursing (DON) on 08/17/23 at 11:06 AM the DON explained that it was the nurses' responsibility to clean the oxygen concentrators once a month and as needed so if the concentrator filters were dusty then they needed to be cleaned more often than monthly. An interview was conducted with the Administrator on 08/17/23 11:46 AM who explained that she expected the oxygen concentrator filters to be cleaned according to the facility policy of monthly and as needed and in Resident #18's case if should have been done as needed. 5. A review of the Invacare Platinum Oxygen Concentrator manual dated 2016 provided by the facility revealed on page 24 section 7.3 Cleaning the Cabinet Filter, CAUTION! Risk of Damage, To avoid damage to the internal components of the unit: - DO NOT operate the concentrator without the filter installed or with dirty filter. Resident #21 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD). A review of Resident #21's physician orders revealed an order dated 07/19/23 of oxygen at 2 liters per nasal cannula. The annual Minimum Data Set assessment dated [DATE] revealed Resident #21 was cognitively intact and received supplemental oxygen therapy. A review of Resident 21's care plan revised on 07/24/23 indicated the Resident was at risk for respiratory difficulty related to oxygen therapy. The goal to not have respiratory complications would be attained by utilizing interventions such as monitoring for respiratory distress and administering oxygen as ordered. A review of Resident #21's Treatment Administration Record (TAR) dated 08/2023 revealed the oxygen had been administered every day. The TAR also indicated on 08/01/23 the oxygen concentrator filters were to be checked and cleaned monthly and PRN (as needed) every night shift on the first of the month. On 08/01/23 the TAR was initialed by Nurse #3 which indicated the treatment had been done. An interview and observation were made of Resident #21 on 08/14/23 at 11:25 AM. The Resident was sitting in his wheelchair at his bedside and wore oxygen via nasal cannula. The Resident stated he received oxygen at 2 liters per minute which was what the oxygen concentrator was set at. It was also noted that the two bilateral external filters were missing off the oxygen concentrator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation made on 08/15/23 at 8:50 AM of Resident #21's oxygen concentrator. The external filters were still missing. On 08/15/23 at 2:40 PM an interview was conducted with Nurse #4 who explained that she was responsible for Resident #21 when she had to cover for the medication aide. The Nurse explained that the oxygen filters were checked and cleaned every week or two by the housekeeping department because they had the stuff used to clean the filters. During the interview the Nurse observed that there were no external filters on Resident #21's oxygen concentrator and stated, it does not surprise me and walked out of the room. An interview was conducted with the Unit Manager (UM) on 08/15/23 at 3:09 PM. The UM explained that the third shift nurses were responsible for checking and cleaning the oxygen concentrator filters once a month on the 15th and as needed. She stated the facility had undergone remodeling recently and the external filters were more likely to be dusty and needed to be cleaned more than once a month. When the UM was informed that multiple observations were made of Resident #21 not having external filters on his oxygen concentrator, she remarked that the nurse should have gotten a new concentrator for Resident #21, or the nurse should have made sure that someone on first shift got the Resident a new concentrator. On 08/15/23 at 10:15 PM an interview was made with Nurse #3. The Nurse explained that the oxygen concentrator filters were cleaned once a month and the schedule would be on the TAR. The Nurse stated she did not remember when she cleaned the Resident's filter last or even if the Resident had filters on his concentrator but if her initials were on the TAR then she cleaned the filters. On 08/16/23 at 2:00 PM an observation of Resident #21's oxygen concentrator remained without the two external filters. Attempts were made to interview the Respiratory Therapist, but the attempts were unsuccessful. During an interview with the Director of Nursing (DON) on 08/17/23 at 11:06 AM the DON explained that it was the nurses' responsibility to check and clean the oxygen concentrators once a month and as needed and if the external filters were missing then the nurse should have changed out the concentrator. The DON was informed that the missing filters was brought to Nurse #4's attention on 08/15/23 and as of last round on 08/16/23 the oxygen concentrator remained in the Resident's room and the DON stated Nurse #4 should have made sure that something was done about the missing filters even if it was to change out the oxygen concentrator herself. An interview was made with the Administrator on 08/17/23 at 11:48 AM who stated Resident #21's oxygen concentrator should have been changed out when it was brought to the nurse's attention that there were no external filters on his concentrator. 47478 6. Resident #65 was admitted to the facility on [DATE]. Resident #65 had diagnosis that included Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #65's medical record stated that a physician order dated 09/15/2022 read: Oxygen at 2 liters per minute as needed. (continued on next page)

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	08/17/2023

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #65's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #65 was cognitively intact. She was receiving oxygen during the assessment reference period. An observation was completed of Resident #65 on 08/14/23 at 10:06 AM where her oxygen was noted to be running at 2 liters per minute (LPM). The oxygen concentrator had two external filters that were white in color from the dust particles. (The color of the filters were supposed to be black with no white from dust particles.) Resident #65 did not appear to be in any respiratory distress. An additional observation and interview were completed with Resident #65 on 08/15/23 2:54 PM where resident was resting in bed without her oxygen on. She did not have any signs or symptoms of shortness of breath. The two-filters on the concentrator continued to be white in color from the dust particles. Resident #65 stated that she only wore oxygen at night. She stated that she had COPD and had some coughing however it was not all the time. An interview was completed with Nurse #4 on 08/15/23 at 2:43 PM. Nurse #4 stated that she was assigned to Resident #65. She stated that she cleaned the concentrator daily and monitored the oxygen daily by ensuring that the concentrator settings were correct as ordered. She stated that oxygen filters and tubing were to be changed and cleaned on third shift weekly. She also stated that concentrators should be dusted off. Accompanied Nurse #4 to Resident #65's room to demonstrate the white colored filters. Nurse #4 stated that she would change the filter immediately. An interview with the Unit Manager was conducted on 08/15/23 at 3:03 PM. She stated that filters on the oxygen concentrators should be cleaned monthly and as needed by the nurse assigned to the unit. Unit Manager stated that she would expect the oxygen filters to be clean, she added that the facility has had more dust due to the recent remodel, but she would expect the staff to clean them. An observation of Resident #65 was conducted on 08/16/23 at 3:49 PM. Resident #65 was resting in bed with her oxygen concentrator next to her, the external filers were noted to have been cleaned and were free from dust and debris. An interview with Nurse #1 was conducted on 8/17/23 at 6:56 AM. Nurse #1 stated that oxygen filters were washed and laid out to dry by the third shift nursing staff on a monthly basis and as needed. The Director of Nursing (DON) was interviewed on 08/17/23 at 10:32 AM. The DON stated that the oxygen filters were scheduled to be cleaned or changed once a month and when visibly soiled. The DON stated that the facility may need to adjust the frequency of the cleaning of oxygen filters so that the dust did not build up. She stated that the facility had recently been undergoing some renovations and believed that the increase in dust particles came from that construction.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 35789 Based on observations, record reviews, staff, resident, and Physician Assistant interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey of 03/18/22. This failure was for 1 deficiency that was originally cited in the area of Quality of Care (F695) and was subsequently recited on the current recertification and complaint survey of 08/17/23. The repeat deficiency during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: F695: Based on observations, record review, staff, resident, and Physician Assistant interviews the facility failed to ensure a Bilevel Positive airway Pressure (BiPAP) machine (machine used to push air into your lungs), was in working order (Resident #38), failed to ensure oxygen concentrators and filters were clean (Resident #6, Resident #9, Resident #18, Resident #21, and Resident #65), and failed to ensure an oxygen flow rate was at the prescribed rate (Resident #6). This affected 6 of 6 residents reviewed for respiratory care. During the recertification and complaint survey of 03/18/22 the facility failed to secure an oxygen tank that was stored upright on the floor in the resident room. The Administrator was interviewed on 08/17/23 at 11:16 AM who stated the quality assurance committee met monthly and included the Medical Director and all department heads. The Administrator added the consultant pharmacist attended the quality assurance committee meetings quarterly. She explained that during the meetings they went over every department in the facility included previous minutes, clinical systems, rehospitalization s, care delivery, operations, educations, financials, safety issues, any policy issues, and grievances. The Administrator stated that after all departments had been reviewed the Medical Director gave his input on ways to improve things. She further explained that the implemented interventions from the previous recertification survey continued but the audits had stopped, and she felt like the facility had achieved ongoing compliance. The Administrator stated that the facility would have to implement procedures to ensure all respiratory devices were functioning properly and cleaned and monitor them more closely to ensure nothing fell to the wayside.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37280 Based on observation, record review and staff interviews, the facility failed to change gloves and perform hand hygiene after the Wound Nurse removed a soiled dressing with drainage on it and before cleansing a stage IV sacral wound with a gauze soaked with normal saline for 1 of 1 staff member observed during wound care (Wound Nurse). The finding included: A review of the facility's policy titled Dry/Clean Dressing, a MED-Pass Inc. policy revised 09/2013, read in part the purpose of this procedure is to provide guidelines for the application of dry, clean dressings. Under Steps in the Procedure listed as followed, #5. Wash and dry hands thoroughly. #6. Put on clean gloves and remove soiled dressing. #7. Pull glove over dressing and discard. #8. Wash and dry your hands thoroughly. #13. Put on clean gloves. #15. Cleanse wound with ordered cleanser. #17. Apply the ordered dressing. On 08/15/23 at 2:19 PM an observation of a pressure ulcer dressing change was performed by the Wound Nurse. The Nurse washed her hands and donned clean gloves before she removed the soiled dressing from Resident #86's stage IV sacral wound which was saturated with a moderate amount of brown drainage. The Nurse then picked up the presoaked normal saline gauze and proceeded to clean the wound bed and surrounding area then removed her gloves and donned a clean pair of gloves without washing or sanitizing her hands before she donned the new pair of gloves. The Wound Nurse then packed the wound with tissue rebuilding crystals and applied a restoration ointment before packing the wound with an absorbent dressing and applying a super absorbent border dressing. The Nurse then removed her gloves and washed her hands. An interview was conducted with the Wound Nurse on 08/15/23 at 2:24 PM. The Wound Nurse was asked to detail her performance of the wound treatment that she had just completed on Resident #86's sacral wound and with a few seconds of thought the Wound Nurse stated, Oh, I changed my gloves at the wrong time. The Nurse explained that she should have removed her soiled gloves and washed her hands after she removed the soiled dressing and put on a new pair of gloves to clean the wound and apply the ordered treatment. She stated she was nervous and forgot to change her gloves. An interview was conducted with the Infection Preventionist on 08/15/23 at 3:15 PM. The Infection Preventionist explained that she had not reviewed the Wound Nurse's wound care technique recently, but she had not received any reports of concerns about her technique. She continued to explain that she expected the Wound Nurse to remove her gloves and wash or sanitize her hands and don a new pair of clean gloves after she removed the soiled dressing and before she cleaned the wound. During an interview with the Director of Nursing (DON) on 08/17/23 at 11:12 AM the DON explained that the Wound Nurse rounded with the Wound Provider twice a week and she had not received any concerns of inappropriate wound treatment technique from the Wound Provider. The DON continued to explain that she felt that the Wound Nurse was nervous being watched during her performance but nevertheless, she expected the Wound Nurse to remove her soiled gloves and sanitize her hands after she removed the soiled dressing and before she donned a new pair of gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Administrator on 08/17/23 at 11:42 AM. The Administrator stated she expected the Wound Nurse to have followed the facility policy for proper technique for wound treatments.