DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An amended Statement of Deficiencies was provided to the facility on 03/15/16 to correct typographical errors that were in the facility's original CMS 2567 report. Event ID# QI5V11.	F 000	Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of the State and Federal law.	
F 174 SS=D	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and review of the facility's "Resident Handbook" the facility failed to provide private telephone access for 2 of 2 sampled residents (Residents #18 and #104). The findings included: 1. Review of the facility's "Resident Handbook" under the heading of "Private Telephones" on page 4 stated in part: "A portable phone is located at the nurses' station for resident use." Review of the medical record revealed Resident #18 was admitted to the facility on 06/12/12.	F 174	F 174 – Right to Telephone Access with Privacy A cordless telephone was purchased on February 26, 2016 at 2:59pm. The phone was placed at the nursing station which is located central to all resident rooms. The phone is capable of use in a private location if preferred by the resident. Resident #18 was verbally notified of the cordless phone on February 26, 2016 by the Administrator. All residents, including Resident #104, were notified on February 29, 2016 and March 1, 2016 via written communication in the Resident Daily Newsletter. To ensure quality assurance, an additional cordless phone was purchased on 3/15/16 as a back-up phone in the event the existing cordless phone should become non-operative. If the back-up phone is used, another back-up will be purchased to replace it. The maintenance department will check operations of the phone weekly with preventative maintenance checks. Results of the audit will be reviewed in the Quality Assurance Meeting for at least three consecutive meetings. Additional QAA Meeting reviews will occur if indicated. All corrective action will be completed on or before Monday, March 21, 2016.	

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

LNHA — Administrator — 3/21/16

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.

DHSR Black Mountain RO Received MAR 22 2016 by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 174	Continued From page 1	F 174		

Review of the quarterly Minimum Data Set (MDS) dated 12/01/15 revealed Resident #18's cognition was moderately impaired.

Observations on 02/24/16 at 11:09 AM revealed Resident #18 was sitting in her wheelchair at the nurses' station. Resident #18 stated she wanted to call her husband. The desktop phone had been placed on the top of the nurses' station counter which just above the top of Resident #18's head when she was seated in her wheelchair. The Administrator dialed the phone number for Resident #18 but did reach the family member.

Observations of the facility on 02/24/16 at 4:19 PM revealed the nurses' station was located centrally at the top of the 4 resident hallways and the main entrance hallway. Further observations the nurses' station revealed there were 2 desktop telephones and neither of them were cordless.

A subsequent observation on 02/25/16 at 12:35 PM revealed Resident #18 was sitting in her wheelchair at the nurses' station talking on the desktop telephone which had been placed on top of the nurses' station counter. Staff members and visitors walked past Resident #18 the entire time she was on the phone and her conversation could be overheard.

An interview with the Administrator on 02/26/16 at 2:19 PM revealed there had not been a cordless phone available for resident use for approximately 2 weeks. The Administrator explained the cordless phones kept breaking and the facility had ordered a phone they hoped would be more durable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 174	Continued From page 2	F 174		

During an interview on 02/26/16 at 3:30 PM Resident #18 stated she always talked on the desktop phone at the nurses' station.

2. Review of the facility's "Resident Handbook" under the heading of "Private Telephones" on page 4 stated in part: "A portable phone is located at the nurses' station for resident use."

Review of the medical record revealed Resident #104 was admitted on 03/06/14.

Review of the annual Minimum Data Set (MDS) dated 03/16/15 revealed Resident #104's cognition was moderately impaired.

During an interview on 02/22/16 at 3:21 PM Resident #104 stated he did not have his own telephone and always used the desktop phone at the nurses' station which was not private.

Observations of the facility on 02/24/16 at 4:19 PM revealed the nurses' station was located centrally at the top of the 4 resident hallways and the main entrance hallway. Further observations the nurses' station revealed there were 2 desktop telephones and neither of them were cordless.

An interview with the Administrator on 02/26/16 at 2:19 PM revealed there had not been a cordless phone available for resident use for approximately 2 weeks. The Administrator explained the cordless phones kept breaking and the facility had ordered a cordless phone they hoped would be more durable.

A follow up interview was conducted with Resident #104 on 02/26/16 at 4:13 PM. Resident #104 stated he had never used a portable phone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 174	Continued From page 3 and was not aware of a cordless phone available for resident use. Resident #104 further stated he would like to be able to talk on the phone in his room.	F 174	F 241 – Dignity and Respect of Individuality Nurse #2 was individually in-serviced by the Director of Nursing on March 15, 2016. Nurse #2 verbally acknowledged understanding for the need to knock before entering a resident's room and the importance related to promoting care in a manner which enhances a resident's dignity and respect in full recognition of his or her individuality. All staff participated individually in an online Relias interactive training titled, "Resident's Rights Essentials" between the dates of March 6, 2016 to March 18, 2016. This training covered resident rights including the need to knock and identify oneself prior to entering a resident's room. It also explained the importance of maintaining a resident's dignity and respect. The Assistant Director of Nursing in-serviced staff on March 3, 2016. This in-service was related to dignity, privacy, and knocking on doors before entering a room. To ensure quality assurance, Nurse Administration will observe minimum of (5) five staff members per day for two weeks and ten staff members per week for one month. This observation will include knocking, announcing, and waiting for a resident's response prior to entering a resident's room. The results of this audit will be presented for two consecutive Quality Assurance Meetings. Additional findings will be presented to the QAA Committee as further indicated. All corrective action will be completed on or before Monday, March 21, 2016	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to knock on residents' room doors and ask for permission to enter residents' rooms prior to entering two of three residents observed during a medication pass. (Resident #26, Resident #15). The findings included: 1. Resident #26 was admitted to the facility on 10/27/14 with multiple diagnoses including diabetes mellitus (DM), heart failure, and anxiety disorder. A review of the most recent quarterly Minimum Data Set (MDS) assessment dated 01/20/16 identified Resident #26 as having adequate hearing, cognitively intact, and visually impaired. During an observation for medication pass on 02/24/16 at 3:50 PM, Nurse #2 was observed entering Resident # 26's room to administer medication for Resident #26 without knocking on	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4	F 241		

the room door and waiting for the resident to give permission to enter.

In an interview conducted with Resident #26 on 02/26/16 at 12:22 PM, Resident #26 stated that due to her impaired vision, she expected facility staff to knock on her room door, identify themselves, and wait for her permission before entering her room. Resident # 26 added she would be annoyed to find someone in her room without prior acknowledgment.

An interview was conducted with Nurse #2 on 02/26/16 at 5:34 PM. Nurse #2 admitted that she had forgotten to knock on Resident #26's room door and wait for her permission before entering her room to administer medications. She stated that she would normally knock on resident's room door and wait for the permission prior to entering. She added she had too many things on her mind that day and she failed to knock on the resident's door before entering the room.

In an interview with Assistant Director of Nursing (ADON) on 02/26/16 at 6:11 PM, he stated that facility staff were expected to knock on resident's room door, wait for resident to respond for permission to enter prior to entering, and announce themselves after entering a resident room.

An interview was conducted with Administrator on 02/26/16 at 6:28 PM. The Administrator stated that it was her expectation for all facility staff to knock on residents' room door each time before entering the resident's room. After knocking, she expected the facility staff to wait for resident's response before entering. Upon entering the room, she expected facility staff to announce

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 5	F 241		

themselves. She added all of the above training was covered during employee orientation.

2. Resident #15 was admitted to the facility on 02/06/14 with multiple diagnoses including diabetes mellitus (DM), heart failure, and Alzheimer's disease.

A review of the most recent quarterly Minimum Data Set (MDS) assessment dated 02/03/16 identified Resident #15 as having adequate hearing, moderately impaired cognition, and impaired vision.

During an observation for medication pass on 02/24/16 at 3:55 PM, Nurse #2 was observed entering Resident #15's room to administer medication for Resident #15 without knocking the room door and waiting for the resident to give permission to enter.

In an interview conducted with Resident #15 on 02/26/16 at 12:48 PM, Resident #15 stated he would expect facility staff to knock on the room door prior to entering his room. Unfortunately, it did not happen all the time. According to Resident # 15, he considered the room as his home. He did not want anyone entering his home without knocking on the room door, waiting for his permission prior to entry, and acknowledging themselves after entry.

An interview was conducted with Nurse #2 on 02/26/16 at 5:34 PM. Nurse #2 admitted that she had forgotten to knock on Resident #15's room door and wait for his permission before entering his room to administer medications. She stated that she would normally knock on resident's room door and wait for the permission prior to entering.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 6 She added she had too many things on her mind that day and she failed to knock on the resident's door before entering the room. In an interview with Assistant Director of Nursing (ADON) on 02/26/16 at 6:11 PM, he stated that facility staff were expected to knock on resident's room door, wait for resident to respond for permission to enter prior to entering, and announce themselves after entering resident room. An interview was conducted with Administrator on 02/26/16 at 6:28 PM. The Administrator stated that it was her expectation for all facility staff to knock on residents' room door each time before entering resident's room. After knocking, she expected the facility staff to wait for resident's response before entering. Upon entering the room, she expected facility staff to announce themselves. She added all of the above training was covered during employee orientation.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to repair a broken foot board on a bed in 1 occupied resident room on 1 of 4 resident halls (Resident room #214B), failed to change a soiled privacy curtain in 1 of 1 resident room on 1 of 4 resident halls (Resident room	F 253	F253 – Housekeeping & Maintenance Services Resident #214B's bed was temporarily repaired on 2/26/16 by the Maintenance Director to ensure safety. A new bed was ordered for Resident #214B on 2/26/2016 by the Administrator. The bed arrived on 3/4/16 and was placed in the room of Resident #214B by the Maintenance Assistant.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 7 #305A) and failed to remove or store toilet plungers in plastic bags that were left on the bathroom floors of 2 resident rooms on 1 of 4 resident halls (Resident room #305 and #307). Findings included: 1. Observation on 02/23/16 at 11:51 AM in room #214B revealed the foot board of the bed was broken in the top right corner and was taped with plastic tape. Observations of the hard plastic molding that encircled the edges of the footboard was also broken in the top right corner with rough edges when touched and was partially taped with plastic tape. A section in the center of the footboard had a long scrape and was broken. Observation on 02/24/16 at 4:11 PM in room #214B revealed the foot board of the bed was broken in the top right corner and was taped with plastic tape. Observations of the hard plastic molding that encircled the edges of the footboard was also broken in the top right corner with rough edges when touched and was partially taped with plastic tape. A section in the center of the footboard had a long scrape and was broken. Observation on 02/25/16 at 12:22 PM in room #214B revealed the foot board of the bed was broken in the top right corner and was taped with plastic tape. Observations of the hard plastic molding that encircled the edges of the footboard was also broken in the top right corner with rough edges when touched and was partially taped with plastic tape. A section in the center of the footboard had a long scrape and was broken. During an interview and observation on 02/26/16 at 12:42 PM the Maintenance Director confirmed	F 253	An audit of all resident beds was completed on 2/26/16 by the Administrator, Assistant Administrator, Corporate Director of Compliance, and Western Regional Clinical Services Manager. Any bed noted to have a headboard or footboard in poor condition was replaced on this day by the facility Maintenance Department. To ensure quality assurance, Administrative staff will observe headboards and footboards Monday thru Friday during administrative rounds. Findings from these rounds will be presented to the Administrator, Assistant Administrator, or designee in a daily Administrative Meeting held Monday thru Friday. The Manager on Duty, covering Saturday and Sunday, will communicate any urgent repair issues to the maintenance personnel on call. Minor repairs will be placed in the Maintenance Work Order Log at the nurse desk. The privacy curtain in Room #305A was replaced on 2/26/16. Privacy curtains in all resident rooms were audited between March 1, 2016 and March 4, 2016. Any curtains found to be soiled were replaced. Housekeeping staff was in-serviced on March 14, 2016 by the Environmental Services Director to monitor curtains daily with a special focus on privacy curtains every Monday. To ensure quality assurance, Administrative staff will observe privacy curtains Monday thru Friday during administrative rounds. Findings from these rounds will be presented to the Administrator in a daily Administrative Meeting held Monday thru Friday.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 8 his department worked on resident beds and when they tore up they fixed them. He explained there was a work order book at the nurse's station for staff to write on when repairs were needed and he checked the book as he made rounds throughout the day but if a repair was urgent staff should call the maintenance department. He explained he put a new hand control on the bed in room 214B on 02/25/16 but did not look at the footboard of the bed. He stated he was not aware the foot board on the bed was broken but it must have been like that for a while. He further stated he did not think he could repair it but would need to replace the bed. He confirmed the top right corner of the foot board and the plastic molding was broken and had been taped to hold it in place but he did not know who had taped it. He also confirmed there was an elongated crack in the center of the footboard and it could not be repaired. During an observation and interview on 02/26/16 at 12:49 PM the Administrator confirmed the footboard on the bed in room 214B was broken and the bed would have to be replaced. She stated it was her expectation for staff to report to the maintenance department when equipment was broken. She further stated there was a maintenance log at the nurse's station and she expected staff to fill it out so that repairs could be made in a timely manner. 2. A soiled privacy curtain was observed in Resident Room #305. a. During an observation on 02/23/16 at 01:23 PM the privacy curtain was soiled with brown stains around Resident Bed A. b. An observation was made on 02/24/16 at 11:35 AM the privacy curtain remained soiled with	F 253	The uncovered toilet plungers were removed from Room #305 & #307 on February 26, 2016 by the Environmental Services Director. An audit of all resident restrooms was completed on March 1, 2016 by the Administrative staff to ensure all restrooms were free of uncovered plungers. Housekeeping staff was in-serviced on March 14, 2016 by the Environmental Services Director. This in-service instructed staff on the proper technique and storage for soiled items, specifically toilet plungers. To ensure quality assurance, Administrative staff will observe resident bathrooms Monday thru Friday during administrative rounds. Findings from these rounds will be presented to the Administrator, Assistant Administrator, or designee in a daily Administrative Meeting held Monday thru Friday. Findings for all Maintenance and Housekeeping services will be presented to the QAA Committee for at least two consecutive meetings. Additional findings will be presented to the QAA Committee as further indicated. All corrective action will be completed on or before Monday, March 21, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 9	F 253		

brown stains.
c. An observation was made on 02/24/16 at 3:39 PM the privacy curtain remained soiled with brown stains.
d. An observation was made on 02/25/16 at 9:14 AM the privacy curtain remained soiled with brown stains.
e. An observation was made on 02/26/16 at 11:40 AM the privacy curtain remained soiled with brown stains.

3. Two toilet plungers were observed not bagged sitting on the floor next to the toilet of the adjoining bathroom for room 305 and 307.

a. During an observation on 02/23/16 at 01:23 PM observed 2 toilet plungers not in bags on the floor in the adjoining bathroom of room 305 and 306.
b. An observation was made on 02/24/16 at 11:35 AM where the plungers remained in the bathroom not bagged.
c. An observation was made on 02/24/16 at 3:39 PM where the plungers remained in the bathroom not bagged.
d. An observation was made on 02/25/16 at 9:14 AM where the plungers remained in the bathroom not bagged.
e. An observation was made on 02/26/16 at 11:40 AM where the plungers remained in the bathroom not bagged.

During interview on 02/25/16 at 11:29 AM Housekeeper #1 and Housekeeper #2 stated they cleaned the rooms and resident bathrooms daily and as needed. The daily cleaning included changing privacy curtains if they were soiled and mopping the floors of the rooms and bathrooms including removing toilet plungers as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 10 During interview and tour on 02/26/16 at 6:16 PM the Administrator and the Director of Nursing (DON) verified the privacy curtain in room 305 was soiled and the 2 toilet plungers in the adjoining bathrooms of room 305 and 307 were not bagged. The Administrator and the DON stated it was their expectations for the staff to change the soiled privacy curtain and for the toilet plungers to be either bagged or removed from the bathroom.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278	F 278 – Assessment Accuracy/Coordination/Certified, The MDS Assessment for Resident #108 was corrected on February 25, 2016. The last comprehensive assessment dated 9/2/15 was changed to reflect the resident's dental status as edentulous, without any natural teeth or teeth fragments. This corrected assessment was re-submitted on February 25, 2016 by the RN, MDS Coordinator. A visual audit of all residents' mouths was completed by the Director of Nursing, Assistant Director of Nursing, and MDS Coordinator on March 21, 2016. Any resident found to have been coded inappropriately on his or her most recent MDS assessment were corrected and re-submitted by the RN MDS Coordinator between the dates of February 25, 2016 and March 21, 2016. The Interdisciplinary Team consisting of the MDS Coordinator, Dietary Manager, Social Worker, and Activity Director reviewed all active residents most recent Comprehensive Assessment on March 21, 2016 for accuracy. Any areas of inaccuracy were corrected and resubmitted on March 21, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to code the Minimum Data Set (MDS) accurately for residents in the areas of oral/dental status for 1 of 3 sampled residents (Resident #108). The findings included: Resident #108 was admitted to the facility on 10/28/14 with multiple diagnoses including Diabetes Mellitus (DM), high blood pressure, and depression A review of the most recent annually Minimum Data Set (MDS) assessment dated 09/02/15 identified Resident #108 as having adequate hearing, being severely cognitively impaired, and visually impaired. In addition, the MDS indicated Resident #108 as having no oral/dental status issues. Review of Resident #108's dental record dated 01/09/15 signed by the dentist revealed she was completely toothless when she was not wearing her full upper and lower dentures. On 02/24/16 at 11:38 AM. Resident #108 was observed wearing full upper and lower dentures. When Resident #108 took out her dentures, no natural teeth or tooth fragment(s) were observed in her mouth.	F 278	The Administrator and MDS Coordinator reviewed the RAI Manual on 2/29/16 for appropriate dental status coding. The MDS Coordinator acknowledged understanding to the Administrator on February 29, 2016. To ensure quality assurance, the Interdisciplinary Team will review at least one comprehensive assessment per week for three months to ensure accuracy of MDS. Findings will be presented in the Quality Assurance Meeting for three consecutive meetings. All corrective action will be completed on or before Monday, March 21, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 12 An interview was conducted with MDS Coordinator on 02/26/16 at 6:44 PM. She admitted it was her mistake to code "None of the above" in the oral/dental status of MDS assessment for Resident #108 as the resident was edentulous during the assessment. MDS Coordinator stated the assessment was based on a visual inspection of resident's mouth.	F 278		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that medication error rate was 5% or below as evidenced by 2 errors out of 28 opportunities, resulting in a medication error rate of 7.14 % for 1 of 5 residents observed during medication pass (Resident # 63). The findings included: 1a. Resident # 63 was admitted to the facility on 11/10/14 with multiple diagnoses including diabetes mellitus (DM), and hypokalemia. A review of Resident # 63's medical record revealed a physician's order dated 06/09/15 for Potassium Chloride Extended Release (ER) 20 milliequivalent (mEq) one tablet by mouth once daily for hypokalemia. The physician order specified "Do Not Crush" for this medication.	F 332	F 332 – Free of Medication Error Rates of 5% or More The physician was immediately notified of the medication error for Resident #63. Immediately following the administration of the medications to Resident #63, a medication error form was completed. Resident #63 exhibited no negative outcome from the medication error. All residents Medication Administration Records were audited by the Director of Nursing between March 1, 2016 and March 2, 2016. Any resident receiving Potassium Chloride or Metformin were reviewed to ensure the correct form of drug was being administered depending upon each resident's swallowing status and the ability for the prescribed medication to be crushed. Every resident's Care Guide was audited by the Director of Nursing and Assistant Director of Nursing between March 1, 2016 and March 2, 2016 to ensure accuracy regarding each resident's ability to tolerate whole medications. Nurse #1 was individually in-serviced by the Director of Nursing on March 1, 2016. This in-service consisted of identifying non-crushable medications and the outcome of crushing an extended release medication. All licensed nurses and Medication Aides participated individually in an online Relias interactive training titled, "Medication Administration, Avoiding Common Errors" between March 7, 2016 and March 18, 2016. This training covered Medication Administration and tips for avoiding common medication errors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 13	F 332		

On 02/26/16 at 8:45 AM, Nurse #1 was observed preparing and administering medications to Resident #63. The medications pulled for administration included one tablet of Potassium Chloride ER 20 mEq. Nurse # 1 was observed placing the tablet of Potassium Chloride ER 20 mEq along with other medications into the pill sleeve for crushing. Then, Nurse #1 mixed the crushed medications with apple sauce and administered the medications to Resident # 63.

On 02/26/16 at 9:25 AM, Nurse #1 was interviewed. She stated that she had failed to read the order instructions completely before crushing and administering the Potassium Chloride ER 20 mEq tablet to Resident # 63 that morning. She added she would not have crushed the Potassium Chloride ER 20 mEq if she had read the entire instructions.

An interview was conducted with the Assistant Director of Nursing (ADON) on 02/26/16 at 6:11 PM. He stated it was his expectation that all nurses read and verify each medication order and its instructions completely in the Medication Administration Record (MAR) prior to medication administration to ensure the right resident, medication, dose, dosage form, route of delivery, and all important special instructions would be followed.

1b. Resident # 63 was admitted to the facility on 11/10/14 with multiple diagnoses including Diabetes Mellitus (DM), and hypokalemia.

A review of Resident # 63's medical record revealed a physician's order for metformin ER 500 milligram (mg) two tablets by mouth once

All licensed nurses and Medication Aides were in-serviced by the Assistant Director of Nursing on March 2, 2016. The in-service specifically identified non-crushable medications and steps to avoid medication errors related to non-crushable medications.

To ensure quality assurance, The Director of Nursing or Assistant Director of Nursing will observe Nurse #1 complete a minimum of (10) ten opportunities until 0% medication error rating is obtained.

To ensure quality assurance, The Director of Nursing, Assistant Director of Nursing or designee will observe a minimum of one nurse per week for at least ten opportunities over the next three months. If any nurse is found to exhibit medication errors during observation, he or she will receive in-servicing and schedule another review within two weeks.

To ensure quality assurance, findings of the observations will be presented to the QAA Committee for at least three consecutive meetings. Further observations will be reported if indicated.

All corrective action will be completed on or before Monday, March 21, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 14 daily in the morning and one tablet by mouth once daily at noon was discontinued on 02/24/16. A new physician's order was initiated on 02/24/16 for metformin 500 mg two tablets by mouth once daily in the morning and one tablet by mouth once daily at noon for DM. On 02/26/16 at 8:47 AM, Nurse #1 was observed preparing and administering medication to Resident # 63. The medications pulled for administration included two tablets of metformin ER 500 mg. Nurse # 1 was observed placing the two tablets of metformin ER 500 mg along with other medications into the pill sleeve for crushing. Then, Nurse #1 mixed the crushed medications with apple sauces and administered the medications to Resident # 63. On 02/26/16 at 9:25 AM, Nurse #1 was interviewed. She acknowledged that she had administered metformin ER 500 mg to Resident # 63. She stated that she was not aware of Resident's DM medication had changed from metformin ER 500 mg to metformin 500 mg on 02/24/16. An interview was conducted with the Assistant Director of Nursing (ADON) on 02/26/16 at 6:11 PM. He stated it was his expectation that all nurses were to read and verify each medication order and its instructions completely in the Medication Administration Record (MAR) prior to medication administration to ensure the right resident, medication, dose, dosage form, route of delivery, and all important special instructions would be followed.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 15 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to securely close, label and date opened boxed bags of frozen foods in the freezer to prevent freezer burn. During a tour of the kitchen on 02/22/16 at 9:46 AM with the Dietary Manager (DM) the walk-in freezer temperature was observed at 4 degrees below zero. An observation was made of 4 opened undated boxes of frozen foods opened including 1 bag of frozen cheese pizza slices, ½ bag of dinner rolls, 1 bag of frozen cookie dough and 1 bag of sliced garlic bread. Along the length of the door opening a frost buildup of approximately 2 inches wide was observed on the freezer wall. In addition the exhaust fans, the ceiling and the floor were all observed to have a coating of ice and frost. The DM observed and verified the boxes of frozen foods were opened and there was no dated label of when they were opened. The DM further stated it was her expectation for staff to seal foods after opening them. The DM explained she thought the shipping label was enough.	F 371	F 371 – Food Procure, Store/Prepare/Serve – Sanitary The four opened undated boxes of frozen foods including 1 bag frozen pizza slices, ½ bag of dinner rolls, 1 bag of frozen cookie dough, and 1 bag of sliced garlic bread were disposed on February 22, 2016 at 10:00am by the Food Service Director. The Food Service Director and contract Dietician performed a complete audit of the kitchen and nourishment storage on the resident hall on February 22, 2016 at approximately noon. All other food items were observed to be stored properly with labels, appropriate dating, and proper sealing. The Dietary Manager was in-serviced by the Dietician on February 22, 2016 regarding proper labeling and storage of open items. All Dietary staff was in-serviced by the Dietary Manager on February 22, 2016 regarding proper labeling and storage of open items. To ensure quality assurance, The Dietary Manager or designee will continue to perform a daily food storage inspection by 9:00am daily and present the findings to the Administrator. In addition to this daily inspection, the Administrator or Assistant Administrator will perform a weekly food storage inspection. The Dietician will provide a food storage inspection at least once per month. To ensure quality assurance, the results of these findings will be presented in the Quality Assurance Meeting for a minimum of six months or six consecutive meetings. All corrective action will be completed on or before Monday, March 21, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 16 During an interview on 02/26/16 at 6:16 PM the Administrator stated it was her expectation that packaged food items were dated, labeled, and securely closed when opened.	F 371		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, review of daily monitoring sheets for the facility's refrigerators, and staff interviews the facility's Quality	F 520	F 520 – Committee-Members/Meet/Quarterly/Plans The facility has a Quality Assurance Committee consisting of the Medical Director, Director of Nursing, Administrator, Pharmacist, and at least two other members. The QAA Committee meets monthly to review existing and newly identified quality deficiencies. A QAA Program was implemented in August, 2015 for F 371. The daily inspection forms were reviewed daily by the Administrator and findings were presented monthly in the QAA Meeting. To better ensure quality assurance in the procurement of food related to F 371, the Administrator and/or Assistant Administrator will personally perform a food storage audit at least once per week. The contract dietician will also perform an inspection at least once per month. These findings, in addition to the daily inspections, will be presented in the QAA meeting for a minimum of six consecutive meetings. All corrective action will be completed on or before Monday, March 21, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 17	F 520		

Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in August 2015. This was for one recited deficiency which was originally cited in August 2015 and subsequently cited in February 2016 on the current recertification survey. The repeated deficiency was in the area of food storage. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.

The findings included:

This tag was cross referred to:

F 371: Food Procurement, Storage, Preparation, and Distribution. Based on observations and staff interviews, the facility failed to securely close, label and date opened boxed bags of frozen foods in the freezer to prevent freezer burn.

The facility was recited for F 371 for failing to label, date, and securely close the bags of 4 boxes of frozen prepared foods in the freezer to prevent freezer burn. F 371 was originally cited during the August 2015 recertification survey for failing to assure an opened container of a nutritional supplement and sandwiches stored ready for use were dated.

During an interview on 02/26/16 at 7:06 PM the Administrator stated the facility's Quality Assurance (QA) Program had included daily food storage inspections including monitoring of the kitchen's refrigerators and freezer in the QA process. The Administrator could not explain how the frozen foods with opened bags had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	02/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 18 missed during the daily inspection.	F 520		