DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FI	FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0	MB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X:	3) DATE SURVEY COMPLETED
		345246	B. WING _				C 09/20/2022
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
HICKORY	FALLS HEALTH AND RI	EHABILITATION			SUNSET STREET CANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
F 000	investigation survey of through 09/15/22. Th the facility on 09/20/2 immediate jeopary re exit date was chnage was found in complia	ertification and complaint was conducted on 09/12/22 e survey team returned to 22 to validate the facility's moval plan. Therefore, the d to 09/20/22. The facility nce with the requirement ency Preparedness. Event	FC	000			
	survey was conducte 09/15/22. The survey 09/20/22 to validate t jeopardy removal pla was changed to 09/2 (13) complaint allega (1) was substantiated NC00192581, NC007 NC00189327, NC007 NC00183596. Event immediate jeopardy.	complaint investigation d from 09/12//22 through y team returned to the facility he facility's immediate n. Therefore, the exit date 0/22. There were thirteen tions investigated and one d. Event ID# NC00192940, 192500, NC00190395, 189134, NC00184472, and ID# NC00190395 resulted in					
	Past non-compliance CFR 483.12 at tag F of (J).	was identified at: 600 at a scope and severity					
	Immediate Jeopardy	was identified at:					
	CFR 483.12 at tag F of (J).	607 at a scope and severity					
	The tags F 600 and F Substandard Quality						
	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	2E		TITLE		(X6) DATE
	cally Signed						10/14/2022

Electronically Signed

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.

CENTERS FOR MEDICARE & MEDICAND SERVICES OMB NO. 038-0 STINEMENT OF PERIORNOLSS MID PLAN OF CORRECTION (1) IPROVIDERS UNLIDENTIFICATION NUMBER: (2) MULTIFILE CONSTRUCTION A BUILING (2) MULTIF			ID HUMAN SERVICES			PRINTED: 1 FORM AF	PROVE
342246 B. WHG 09/20/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 21P CODE STREET ADDRESS, CITY, STATE, 21P CODE 00 MICKORY FALLS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, 21P CODE 00 STREET CRANTEF FALLS, NC 2005 MICKORY FALLS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, 21P CODE 00 MICKORY FALLS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, 21P CODE 00 MICKORY FALLS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, 21P CODE 00 MICKORY FALLS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, 21P CODE 00 MICKORY FALLS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, 21P CODE 00 MICKORY FALLS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, 21P CODE 00 MICKORY FALLS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, 21P CODE 00 F000 Continued From page 1 FROM CONTROLLS ADDRESS F1000 Free from Abuse and Neglect, and Exploitation ad Bofford in this subpart. This includes but is not limited to freedom from incol and any physical abuse, corporal punishment, or in	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` <i>`</i>		(X3) DATE SUF COMPLET	RVEY
190 SUMSET STREET GRANTE FALLS, NC 2830 Image: PRECENC Stream of the construction of the period by Full. Tag Symmetry and the period by Full. REGULTION OR LSCIDENTFYING INFORMATION) Image: Providence FLAN OF CONRECTION (EACH CONRECTION EACTION SHOULD BE CROSS-REFERENCE) To the APAROPRINT DEFICIENCY) Operation (CROSS-REFERENCE) To the APAROPRINT DEFICIENCY (CROSS-REFERENCE) TO THE REFERENCE TO THE APAROPRINT DEFICIENCY (CROSS-REFERENCE) To the APAROPRINT DEFICIENCY (CROSSS-REFERENCE) TO THE REFERENCE TO THE APAROPRINT DEFICIENC			345246	B. WING _			2022
HICKORY FALLS HEALTH AND REHABILITATION GRANTE FALLS, NC 28630 (W10) PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECED BY FULL REGULATION OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS 74.00 CORRECTION (EACH DEFICIENCY) 0(9) (CROSS-REFERENCE TO THE APPROPRIATE DEFINITION (CROSS-REFERENCE TO THE APPROPRIATE DEFINITION (CROSS-REFERENCE DEFINITION (CROSS-REFERENCE DEFINITION (CROSS-REFERENCE DEFINITION (CROSS-REFE	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
CAN ITE FALLS, K2 2680 PHERIX TAG SUMMARY STATEMENT OF DEFICIENCIES (#CAT OPERCENCY MARTE PRECIDEND BY FULL REGULATORY OR LSCIENTIFYING INFORMATION) Deficition Compact (#CAT OPERCENCY ALSCIENTIFYING INFORMATION) Deficition Deficition F 000 Continued From page 1 Immediate Jeoparty begins on 06/13/22 and was removed on 09/18/22. An extended survey was conducted. F 000 F 600 F 600 S483.12(a)(1) S483.12(a)(1) S483.12(a)(1) S483.12(a)(1) F 600 F 600 S483.12(a) The facility must- S483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion: This RECULIENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect ar esident from verbal and physical abuse, when Nurse Ald(E (MA) # 2 proceeded to provide care to a resident (Resident #257) while he was agitated and comba	HICKORY	FALLS HEALTH AND RE			100 SUNSET STREET		
Preprint Tag (EACH OFFICIENCY MAITS BE PRECIDED BY FULL REGULATORY OR US DEMEMPING INFORMATION) PREINX Tag CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 Continued From page 1 Immediate Jeopardy began on 06/13/22 and was removed on 09/18/22. An extended survey was conducted. F 000 F 600 Free from Abuse, and Neglect SS=J CFR(s): 483.12(a)(1) F 600 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not meta sevidenced by; Past noncompliance: no plan of correction required. S483.12(a) The facility must- gata abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not meta as evidenced by; Past noncompliance: no plan of correction required. Past noncompliance: no plan of correction required. #21 taunted, aggressively pushed, aggressively turned, slapped the resident on the hip, and grabbed his arms and held them on his neck resulting in the resident as min, are you trying to choke me," and leaving a bruise on his right hand and redness to his chest for 1 of 3 residents reviewed for abuse (Resident #257).					GRANITE FALLS, NC 28630		
Immediate Jeopardy began on 06/13/22 and was removed on 09/18/22. An extended survey was conducted. F 600 F 600 Free from Abuse and Neglect F 600 SS=J CFR(s): 483.12 (a)(1) F 600 S483.12 Freedom from Abuse, Neglect, and Exploitation F 600 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical othemical restraint not required to treat the resident's medical symptoms. S483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Past noncompliance: no plan of correction required. Based on record review and staff interviews the facility failed to protect a resident from verbal and physical abuse when Nurse Aide (NA) #2 proceeded to provide care to a resident (Resident #257) while he was agitated and combative. NA #2 taunted, aggressively pushed, aggressively turmed, slapped the resident on the hip, and grabbed his arms and held them on his neck resulting in the resident asking, "are you trying to choke me," and leaving a bruise on his right hand and redness to his chest for 1 of 3 residents reviewed for abuse (Resident #257). Past noncompliance: no plan of	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE CO THE APPROPRIATE	OMPLETION
Immediate Jeopardy began on 06/13/22 and was removed on 09/18/22. An extended survey was conducted. F 600 F 600 Free from Abuse and Neglect F 600 SS=J CFR(s): 483.12(a)(1) F 600 \$483.12 Freedom from Abuse, Neglect, and Exploitation Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. \$483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not meta sevidenced by; Past noncompliance: no plan of correction required to protect a resident from verbal and physical abuse when Nurse Aide (NA) #2 proceeded to protect a resident (Resident #257) while he was agitated and combative. NA #2 taunted, aggressively pushed, aggressively pushed, aggressively pushed, aggressively in the resident bis con his neck resulting in the resident asking, "are you trying to choke me," and leaving a bruise on his night hand and redness to his chest for 1 of 3 residents reviewed for abuse (Resident #257). Past noncompliance: no plan of correction required.	F 000	Continued From page	e 1	FO	00		
SS=J CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misapropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restrain not required to treat the resident's medical symptoms. §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect a resident from verbal and physical abuse when Nurse Aide (NA) #2 proceeded to provide care to a resident (Resident #257) while he was agitated and combative. NA #2 taunted, agressively pushed, agressively turned, slapped the resident asking, "are you trying to choke me," and leaving a bruise on his right hand and redness to his chest for 1 of 3 residents reviewed for abuse (Resident #257).		Immediate Jeopardy removed on 09/18/22	began on 06/13/22 and was				
Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect a resident from verbal and physical abuse when Nurse Aide (NA) #2 proceeded to provide care to a resident (Resident #257) while he was agitated and combative. NA #2 taunted, aggressively pushed, aggressively turned, slapped the resident on his neck resulting in the resident asking, "are you trying to choke me," and leaving a bruise on his right hand and redness to his chest for 1 of 3 residents reviewed for abuse (Resident #257).				F 6	00		
		Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's m §483.12(a) The facilit §483.12(a)(1) Not use physical abuse, corpo involuntary seclusion This REQUIREMENT by: Based on record rev facility failed to protect physical abuse when proceeded to provide #257) while he was a #2 taunted, aggressiv turned, slapped the re grabbed his arms and resulting in the reside choke me," and leavin and redness to his ch	right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. ry must- e verbal, mental, sexual, or oral punishment, or ; is not met as evidenced iew and staff interviews the ct a resident from verbal and Nurse Aide (NA) #2 care to a resident (Resident gitated and combative. NA vely pushed, aggressively esident on the hip, and d held them on his neck ent asking, "are you trying to ng a bruise on his right hand nest for 1 of 3 residents			olan of	
		The findings included	:				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED
		345246	B. WING				C 20/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKORY	FALLS HEALTH AND RE	HABILITATION			100 SUNSET STREET GRANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 600	4/13/22 with diagnose progressive neurologi and muscle weakness Review of the quarter dated 6/7/22 revealed cognitively impaired a assistance for majorit (ADL). The MDS furth was not coded for bel Resident #257's care the resident was at ris upset and was cognit plan's goal indicated I behaviors would be si to administer medicin monitor effectiveness in mood, sleep pattern behaviors and keep N Review of the facility i 6/14/22 revealed on 6 employee, NA #2, wa combative Resident # resident on his hip an arm to the resident's f revealed NA #1 witne #2, was suspended p 6/13/22. The facility s #2 was terminated. Review of the investig Administrator on 6/13 #257's incident revea -Nurse Aide (NA) #1 s	dmitted to the facility on es which included ical progression, dementia, ical progression, dementia, s dy Minimum Data Set (MDS) d Resident #257 moderately and required extensive y of activities of daily living her revealed Resident #257 haviors. plan dated 4/25/22 revealed sk for episodes of being ively impaired. The care Resident #257's mood and table. Interventions included es per medical director and and be alerted to changes n, appetite, cognition, <i>MD</i> informed. initial allegation report dated S/13/22 at 10:30 PM an s changing the brief of a 4257, and slapped the d pressed the resident's throat. The report further ssed the incident and NA ending investigation on ubstantiated abuse and NA	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES				INTED: 11/07/2022 FORM APPROVED IB NO. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345246	B. WING _			C 09/20/2022
NAME OF PR	OVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZI	P CODE	
				100 SUNSET STREET		
HICKORT	FALLS HEALTH AND RE	HABILITATION		GRANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 600	revealed resident #25 rolled him and slapper statement indicated N resident down and N/ back and he began to grabbed Resident #29 his neck, and he state me?" NA #1 revealed Resident #257 and N are you doing? You w indicated she cared to and the incident was A phone interview cor (NA) #1 on 9/13/22 at NA #2 entered Reside after 7:00 PM to give went to the right side to the left side. NA #1 down the sheet to giv was grabbing at the s agitated muttering. No was commonly agitate speech was unclear. continued to give care Resident #257 tried to aggressively pushed by placing one hand o other on his hip. Resi agitated and pushed at took her right open ha resident on the hip. N smack and she was in happened. NA #2 state What you going to do	ging him. NA #1 further 57 was combative, but NA #2 cd him hard on the hip. The IA #1 tried to calm the A #2 rolled Resident #257 b hit at NA #2. NA #2 57 arms and held them on ed, "what, are you choking care was completed on A #2 stated to NA #1 "what vork to much". NA #1 bo much for the residents very upsetting. Adducted with Nurse Aide t 3:35 PM revealed she and ent #257's room on 6/13/22 care. NA #1 revealed NA #2 of the bed and NA #1 went stated NA #2 started to pull the care and Resident #257 wheet and appeared to be A #1 stated Resident #257 ed when given care and his NA #1 revealed NA #2 to yundoing the brief and to grab at NA #2. NA #2 then Resident #257 on his left hip on his shoulder and the dent #254 became more against NA #2 and NA #2 and and smacked the IA #1 revealed it was a loud	F 6			
		e resident on his back nt #257 was muttering more				

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DEPARTMENT OF HEALT CENTERS FOR MEDICAF						FOR	D: 11/07/2022 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PRO	VIDER/SUPPLIER/CLIA TIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345246	B. WING				C / 20/2022
NAME OF PROVIDER OR SUPPLIE	R			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		ATION		10	0 SUNSET STREET		
HICKORY FALLS HEALTH AI		ATION		GI	RANITE FALLS, NC 28630		
PREFIX (EACH DEFI	CIENCY MUST BE	DF DEFICIENCIES PRECEDED BY FULL IFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
be very angry. F and NA #2 imme wrist and placed his neck in a for Resident #257 s you trying to cho Resident #257 f observed eyes t Resident #257 of appeared to be revealed NA #2 completed care. wanted to move #1 stated she to needed to go ge the cover up on are awful mean themselves". NA and she reported minutes. A follow up phor at 2:08 PM reve previous statem #2 entered Resi to grab at NA #2 indicated NA #2 to give care and right open hand. back and immed and the resident choking me?" N him up in the be get someone in sheet over Resid	pritting his tee gritting his tee desident #257 ediately grabb them down of ceful way. NA tated "what a ock me"? NA # ad quit being o be wide like juit fighting the wide and in sh at this time le NA #1 furthe Resident #25 for someone of the lp. NA #1 Resident #25 for someone of the interview co aled NA #1 to the charg me interview co aled NA #1 re- dent #257's ro then starting rolled the ress slapped the re- slapped the re- sl	re you doing? Are #1 revealed combative and the was scared. e NAs and eyes hock. NA #1 t go of his wrist and r revealed NA #2 7 up in the bed. NA top and that they stated NA #2 threw 7 and stated, "you who pisses on they left the room e nurse within 15 onducted on 9/16/22 anted to clarify her vealed she and NA bom and he began g care. NA#1 ident on his left hip resident with her the resident on his d both his hands t are you doing A #2 wanted to pull said, "stop and let's NA #2 pulled the d left the room g out of the room e comment "you sure	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345246	B. WING				C 20/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
HICKORY	FALLS HEALTH AND RE	HABILITATION			100 SUNSET STREET GRANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	#1 and NA #2 stated room at the same tim incident to the charge clarify when she said incident. NA #1 was us she had told NA #2 to Resident #257. NA # incident happened so slapped the resident at wrist it appeared to be -Nurse Aide (NA) #2 strevealed NA #2 and N #257's room to change revealed the NAs mo both NAs with his har she held Resident #2 keep him from hitting stated "he couldn't br her hands from the re Resident #257 hit her a reflex and hit Resid too. NA #2 indicated I #257 and NA #1 put t lowered the bed, and A phone interview wit unable to be complete -Unit Charge Nurse s revealed NA #1 had of 10:00 PM and stated providing care to Res combative and NA #2 statement further reve went and assessed th called the Director of	they had walked out of the e and NA #1 reported the e nurse. NA #1 was asked to "stop" to NA #2 during the unable to be specific when o stop giving care to 1 continued to state the e quick that when NA #2 and grabbed the resident's e one motion. statement dated 6/14/22 NA #1 entered Resident ge him. NA #2 further ved resident #257 and he hit nds and feet. NA #2 noted 57's arms under hers to both NAs. Resident #257 eathe," and NA #2 removed esident's arms. NA #2 noted to with his fist and NA #2 noted " hit he residents brief on, left the room. h Nurse Aide (NA) #2 was ed after several attempts. tatement dated 6/14/22 come to her last night around that NA #1 and NA #2 were ident #257 and he became " hit the resident. The ealed the Unit Charge Nurse he resident immediately, Nursing (DON), and was " #1 write a statement, and	F	600			

Facility ID: 923052

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		MEDICAID SERVICES				IO. 0938-039	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	TE SURVEY MPLETED	
			A. BUILDING		с		
		345246	B. WING			9/20/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		9/20/2022	
				100 SUNSET STREET			
HICKORY	FALLS HEALTH AND RI	EHABILITATION		GRANITE FALLS, NC 28630			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETION	
F 600	Continued From page	e 6	F 600)			
	member would be in	contact with her the next					
	day.						
	Review of the skin as	ssessment completed by the					
		ated 6/13/22 revealed					
		e resident's chest and a					
	bruise forming on the	e right hand.					
	An interview conduct	ed with the Unit Charge					
		at 3:24 PM revealed NA #1					
		hit Resident #257 on the hip					
		22. The Nurse further					
	revealed she contact	ed the DON immediately and					
		nplete an assessment on					
		NA #1 write a statement on					
		and send NA #2 home					
	•	vas in the shower room worked with any other					
	5	Charge Nurse's assessment					
		257 had a quarter size bruise					
		and and did not show any					
	kind of emotions of b	eing sad, scared, or angry.					
		Resident #257 was unable					
		She revealed both NAs had					
		t #257 numerous times and					
		mbative sometimes. The the NAs had been educated					
		it #257 or an aggressive					
		nbative to either walk away,					
		calm, to complete care.					
	An interview conduct	ed with the Assistant Director					
	• • • •	n 9/14/22 at 5:09 PM					
		trator and the DON joined					
		t after the incident occurred					
		N revealed she assisted the					
		DN with body checks and					
	allempted to Interviev	w Resident #257, but the	1				

Facility ID: 923052

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 11/07/2022 RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	(X3) DA	ITE SURVEY MPLETED
		345246	B. WING				C 09/20/2022
NAME OF P	ROVIDER OR SUPPLIER	·		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
				100	SUNSET STREET		
HICKORY	FALLS HEALTH AND RE	EHABILITATION		GR	ANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 600	Continued From page	e 7	F	600			
	Nursing (DON) on 9/7 she came to the facili the abuse by the Unit assessed Resident #2 right hand and a sma the pressure where N down. The DON state slapping and holding that it wasn't accepta DON it was the reacti combative. The DON was unable to recall to interviewed. DON rev with Resident #257 n could be combative s indicated the NAs had anytime Resident #25 became combative to until they calm, to cor An interview conductor 9/14/22 at 5:55 PM ref facility on 6/13/22 and sent home. The Admin that night. The Admin #257 was unable to d the incident. The Admin further revealed NA #1 an further revealed NA # the Administrator, but Administrator that she 't't mean to and held think it was hard. The	257. The DON further 257 had a small bruise on his Il red mark on his chest from IA #2 had held his arms ed NA #2 admitted to down the resident and knew ble. NA #2 disclosed to the ion of Resident #257 being indicated Resident #257 the incident when realed both NAs had worked umerous times and knew he cometimes. The DON also d been educated that 57 or an aggressive resident be either walk away, or wait mplete care. ed with the Administrator on evealed she arrived at the d NA #2 had already been inistrator revealed full body interviews were completed histrator indicated Resident lisclose information about hinistrator revealed she ad NA #2 the next day. It was #2 denied any incident at first					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:					LETED
							C
		345246	B. WING			09/	20/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKORY	FALLS HEALTH AND RE	HABILITATION			00 SUNSET STREET GRANITE FALLS, NC 28630		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	AIE	DATE
F 600	Continued From page	8	F	600			
	aggressive and NA #2	2 slapped Resident #257 on					
		eeded to grab his wrist and					
	hold his arms down o	n his chest. The ed Resident #257 was the					
		care and NA #2 did not work					
	•	nts that shift. It was revealed					
	both NAs had worked	l with Resident #257 knew he could be combative					
		rted the NAs had been					
	-	e Resident #257 or an					
		ecame combative to either					
	walk away, and wait t care.	ill they are calm, to complete					
		s notified of immediate					
	jeopardy on 9/15/22 a	at 9:00 AM.					
	The corrective action	plan for noncompliance					
	dated 6/15/22 was as						
	On 6/13/22, the Direc	tor of Nursing and initiated a skin sweep on					
		residents assessing for any					
	signs of abuse, as all	residents have the potential					
		weep was completed on					
		ly at 3:00am. No additional ïed. On 6/14/22, the Social					
		rator interviewed all in-house					
		idents with a BIMS of 10 or					
	-	allegations of abuse were					
	-	s verbalized concerns. The cer observed Resident #1 for					
		ould alert to any mental					
		from 6/14/22 to 6/16/22.					
		ognitively impaired and have					
		during care are at higher this deficient practice.					
	Education on the abu	se policy, preventing,					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345246	B. WING				C / 20/2022
NAME OF P	ROVIDER OR SUPPLIER	L	I		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
HICKORY	FALLS HEALTH AND RE	HABILITATION			100 SUNSET STREET GRANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 600	protecting, and report with aggressive beha continued 6/13/22 thr and therapy contract Nursing, Nurse Super Departmental Manage did not receive an edu allowed to work until f The abuse policy, pre- reporting will continue hire orientation. Educe with aggressive beha hire orientation educa completed by the Dire member of the Nursin Director of Nursing ar Nursing Administratio 6-14-22 by the Admin Education on the abu protecting, and report with aggressive beha be provided in the mo the Administrator or D 6 months. The next st July 13 th, 2022 and i The Director of Nursin Administration team of observations of staff v interacting with reside impairment and comb routine audits have be 6/13/22 allegation and of Nursing and Nursir educated by the Adm continue and begin de	ting, and caring for residents vior in long term care ough 6/15/22 for 100% staff staff by the Director of rvisors and Administrative ers. Any staff member who ucation by 6-15-22 was not this education was provided. evention, protecting, and to be provided during new ation on caring for residents viors was added to the new ation on 6-15-22 and will be ector of Nursing or a ng Administration team. The nd the members of the n team was notified on distrator of the new process. se policy, preventing, ting, and caring for residents viors in long term care will onthly All-Staff meeting by Director of Nursing to staff x taff meeting was held on is ongoing monthly. All and the set of the set of the set of the new process. The set of the set of the set of the set of the new process. The set of the set of the set of the taff meeting was held on the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of	F	600			

Facility ID: 923052

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	-	D HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			PLETED
		345246	B. WING				C /20/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
HICKORY	FALLS HEALTH AND RE	HABILITATION			00 SUNSET STREET		
					RANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	until a pattern of comp To ensure continued of Nursing will be respon special focus audits a provided to residents and combative behav	bative behaviors. observations will continue pliance is sustained. compliance, The Director of nsible for bringing the nd observations on care with a cognitive impairment ior to the Quality Assurance w and to make any needed process for three	F	600			
	compliance is sustain Date of Immediate Je On 9/20/22, the facility	-					
	was validated by the f revealed they had rec abuse and how to car combative residents. conducted on all resid	following: Staff interviews erived education on resident er for aggressive and Skin assessments were dents and identified, and idents were interviewed with					
F 607 SS=J	The facility's action pla completed as of 6/15/ Develop/Implement A CFR(s): 483.12(b)(1)-	buse/Neglect Policies	F	607			9/20/22
	§483.12(b) The facility implement written poli §483.12(b)(1) Prohibit neglect, and exploitati misappropriation of re	icies and procedures that: t and prevent abuse, ion of residents and					

Facility ID: 923052

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/07/202 MAPPROVE <u>D. 0938-039</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>			(X3) DATE SURVEY COMPLETED C		
		345246	B. WING			09/20/2022		
NAME OF PI	ROVIDER OR SUPPLIER	I		ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
HICKORY	FALLS HEALTH AND RE	EHABILITATION			00 SUNSET STREET RANITE FALLS, NC 28630			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 607	to investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on record rev facility failed to interv physical abuse and/o for assistance from a licensed staff to stop policies and procedur	sh policies and procedures ch allegations, and e training as required at is not met as evidenced iew, and staff interviews, the ene to stop verbal and r failed to immediately call dministrative staff or the abuse. The facility res failed to include reporting	F	607	F000 Disclaimer Clause Preparation and or execution of this pl does not constitute admission or agreement by the Provider of Truth of facts alleged or conclusion set forth or	n the		
	law enforcement. The abuse to APS and to and local law enforce	rvey agency, APS and local e facility failed to report the the state survey agency, ment within the required residents reviewed for staff esident # 257).			statement of deficiencies. The plan is prepared and executed solely because is required by the provisions of State a Federal law. F607 Develop/Implement Abuse/Negle	e it and		
	facility witnessed veri did not intervene to si licensed staff or admi Immediate Jeopardy when the facility imple allegation of Immedia facility will remain out scope and severity of potential of minimal h jeopardy) to ensure n place effective.	began on 6/13/22 when the bal and physical abuse and top it, or immediately call for inistrative staff to stop it. was removed on 9/18/22 emented a credible the Jeopardy removal. The c of compliance at a lower "D" (no actual harm with a arm that is not immediate nonitoring systems put into			Policies CFR(s): 483.12(b)(1)-(3) The facility failed to intervene to stop verbal and physical abuse and/or failer immediately call for assistance from administrative staff or licensed staff to stop the abuse. The facility policies an procedures failed to include reporting abuse to the state survey agency, APS and local law enforcement. The facility failed to report the abuse to APS and to the state survey agency, and local law	d to nd S / to		
	"Reporting Abuse to I	/ policy and procedure titled Facility Management", with a 2010, read in part "it is the employees, facility			enforcement within the required timeframes for Resident #257. Resident #257 was assessed for injury and left in bed with call light in reach. Nurse Aide#2 was immediately sent	y		

Facility ID: 923052

If continuation sheet Page 12 of 35

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 11/07/202 MAPPROVE O. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345246	B. WING		09	C 0/20/2022
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
				100 SUNSET STREET		
HICKORY	FALLS HEALTH AND RE	EHABILITATION		GRANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	incident or suspected resident abuse, includ source, and theft or n property to facility ma Interpretation and Imp specified in part: 2a. 4 consultants and/or At immediately report ar incidents of abuse to Services. In the abse Nursing Services suc the Nurse Supervisor as the willful infliction confinement, intimida resulting physical har anguish."9. When an suspected or confirm immediately reported regardless of the time occurred. Reporting p followed as outlined i	g physicians, family c., to promptly report any l incident of neglect or ding injuries of unknown nisappropriation of resident anagement." The "Policy plementation" section 4. Employee's facility tending Physicians must ny suspected abuse or the Director of Nursing nce of the Director of the reports may be made to or on duty. "Abuse is defined of injury, unreasonable tion, or punishment with m, pain, or mental incident of resident abuse is ed, the incident must be to the facility management e lapse since the incident	F 60	home. Nurse #1 began abuse it o Nurse Aide #1 immediately a notifying the Director of Nursing Administrator of the alleged ev Nurse Aide #2 to reeducate on policy, prevention, protecting a reporting, and dealing with resi aggressive behaviors in long te Nurse Aide#2 was terminated of On 6/13/22, the Director of Nur Administrative nursing team inis skin sweep on 100% of all in-h residents assessing for any sig abuse, as all residents have th to be affected. This sweep was on 6/14/22. No additional conc identified. On 6/14/22, the Soc and Administrator interviewed a alert and oriented residents with of 10 or higher, to ensure no all abuse were reported. No reside verbalized concerns.	after g and ent with the abuse nd idents with erm care. on 6/14/22. rsing and itiated a ouse ns of e potential s completed erns were ial Worker all in-house th a BIMS llegations of	
	agencies. Resident #257 was a 4/13/22 with diagnose progressive neurolog muscle weakness, ar Review of the quarter dated 6/7/22 revealed moderately cognitivel extensive assistance daily living (ADL). Review of the facility	dmitted to the facility on es which included ical progression, dementia, nd hypertension. rly Minimum Data Set (MDS)		Nurse #1 then in-serviced all o the facility on the abuse policy, protecting and reporting, and p care for residents with aggress behaviors in long term care. The education included what to do abuse and when to report. All s trained in empathy, prevention de-escalation. The Director of and the Administrator arrived at the facility at approximately continue with the investigation Education on the abuse policy, prevention, protecting and repord dealing with residents with agg	prevention, providing sive his if witness to staff were , and Nursing 11pm to of abuse.	

Facility ID: 923052

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		MEDICAID SERVICES				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
					С	
		345246	B. WING		09/20	0/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
HICKORY	FALLS HEALTH AND RE	HABILITATION		100 SUNSET STREET		
				GRANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JIENCY)	(X5) COMPLETIO DATE
F 607	Continued From page	e 13	F 60	7		
		is changing the brief of a		behaviors in long term	care to all staff was	
		\$257, and slapped the		completed on 6/15/22.		
		id pressed the resident's		educated by 6/15/22 w	-	
		throat. The report further		work until education is		
		essed the incident and NA		Regional Operations M	-	
		ending investigation on		the Administrator and t		
	-	substantiated abuse and NA		Nursing on 6/21/22 on		
		he report revealed law		prevention of abuse, pr		
	were not contacted.	It protective services (APS)		staff & visitors, and rep include reporting to The		
	were not contacted.			Personnel Registry and		
	Review of the investion	gation completed by the		Department within 2 ho		
		related to Resident #257's		allegation. On 9/15/22,		
	incident revealed the	following:		were interviewed on the	-	
				was provided on 6/13/2	2-6/15/22 by	
	. ,	statement dated 6/13/22		Administrator and/or de		
		NA #2 hit Resident #257		what is abuse, who rep	-	
		ging him. NA #1 further		do if you witness an ab		
		57 was combative, but NA		report abuse. No issue		
	-	pped him hard on the hip. ted NA #1 tried to calm the		On 9/17/22, the Depart Human Services educa		
		A #2 rolled Resident #257		Administrator on the re		
	back and he began to			reporting to APS. The A		
		57 arms and held them on		educated the Director of		
		ed, "what, are you choking		9/17/22 regarding repo		
		care was completed on		Education on the abuse	e policy,	
		A #2 stated to NA #1 "what		preventing, protecting,		
	are you doing? You w			caring for residents wit		
		oo much for the residents		behaviors in long term		
	and the incident was	very upseung.		provided in the monthly	-	
	A phone interview co	nducted with Nurse Aide		starting July 7/13/22 by or Director of Nursing t		
		t 3:35 PM revealed she and		months.		
		ent #257's room on 6/13/22				
		care. NA #1 revealed NA #2		As of 6/21/22, the Regi	onal Operations	
	-	of the bed and NA #1 went		Manager and/or the Re	-	
	-	stated NA #2 started to pull		Manager will review all		
		e care and Resident #257		allegations to ensure ti	mely reporting to	
	was grabbing at the s	sheet and appeared to be		the State Agency and c	other officials as	

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						NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	TE SURVEY MPLETED
			A. BUILDING	·		С
		345246	B. WING		0	9/20/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		JILOILOLL
				100 SUNSET STREET		
HICKORY	FALLS HEALTH AND RE	EHABILITATION		GRANITE FALLS, NC 28630		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETIO DATE
F 607	Continued From page	e 14	F 60	17		
	agitated muttering. N	A #1 stated Resident #257		required by the regulation,	and to ensure	
		ed when given care and his		that there is no failure for ti		
		NA #1 revealed NA #2		of an allegation to a nurse,	• • •	
	•	e by undoing the brief and		Administrator for three mor		
		o grab at NA #2. NA #2 then		Director of Nursing and Nu	-	
		Resident #257 on his left hip		Administration team condu		
		on his shoulder and the		observations of staff while		
		ident #254 became more against NA #2 and NA #2		and interacting with resider		
	took her right open ha	-		residents. These routine a		
		IA #1 revealed it was a loud		been on-going prior to the		
	smack and she was i			allegation and will continue		
	happened. NA #2 sta	ted" You can't do anything?		of Nursing and Nursing Ad	ministration	
		o?" taunting Resident #257.		team were educated by the		
		2 observed to be frustrated		on 6/14/22 to continue and		
		e resident on his back		documenting their observa		
		nt #257 was muttering more ig his teeth and observed to		while providing care and in residents with a cognitive i		
		ent #257 grabbed at NA #2		combative behaviors. Doc	•	
		ely grabbed the resident's		the observations will contin		
		n down on his chest under		pattern of compliance is su		
	his neck in a forceful	way. NA #1 indicated		issues identified during the		
	Resident #257 stated	l "what are you doing? Are		process will be addressed	promptly. To	
	you trying to chock m			ensure Quality Assurance,		
	-	uit being combative and		be brought to the Quality A		
		d. Resident #257 quit		Performance Improvement		
		eyes appeared to be wide revealed NA #2 at this time		further review and/or need measures for four consecu		
		l completed care. NA #1				
	•	#2 wanted to move Resident		All corrective action will co	mpleted on	
		NA #1 stated she told NA #2		September 20th, 2022.		
		needed to go get help. NA				
		w the cover up on Resident				
	#257 and stated, "you					
	-	on themselves". NA #1				
	-	e room and she reported to				
	-	nin 15 minutes. NA #1				
	revealed she did not		1			

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 11/07/2022 RM APPROVED NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			TE SURVEY MPLETED	
		345246	B. WING			C	C 9/20/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
HICKORY	FALLS HEALTH AND RE	EHABILITATION			SUNSET STREET ANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 607	Continued From page retaliation from NA #2		F	607			
	at 2:08 PM revealed previous statement. N #2 entered Resident : to grab at NA #2 whe indicated NA #2 rolled to give care and slapp right open hand. NA # back and immediately and the resident state choking me?" NA #1 him up in the bed and get someone in here sheet over Resident # together. As they wer NA #1 stated NA #2 roll are mean for someon #1 and NA #2 stated room at the same tim incident to the charge clarify when she said incident. NA #1 was us she had told NA #2 to Resident #257. NA # incident happened so one motion. -Nurse Aide (NA) #2 revealed NA #2 and N #257's room to change revealed the NAs mo both NAs with his har she held Resident #2 keep him from hitting stated "he couldn't br her hands from the re	d the resident on his left hip ped the resident with her #2 rolled the resident on his y grabbed both his hands ed, "what are you doing stated NA #2 wanted to pull d NA #1 said, "stop and let's to help." NA #2 pulled the #257 and left the room re walking out of the room made the comment "you sure the who pisses himself." NA they had walked out of the e and NA #1 reported the e nurse. NA #1 was asked to "stop" to NA #2 during the unable to be specific when o stop giving care to 1 continued to state the o quick that it appeared to be statement dated 6/14/22 NA #1 entered Resident					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345246	B. WING				C 20/2022
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				.	100 SUNSET STREET		
HICKORY	FALLS HEALTH AND RE	HABILITATION			GRANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	too. NA #2 indicated # #257 and NA #1 put t lowered the bed, and A phone interview wit unable to be complete -Unit Charge Nurse s revealed NA #1 had of 10:00 PM and stated providing care to Res combative and NA #2 statement further rever went and assessed th called the Director of instructed to have NA to send NA #2 immed member would be in of day. - Review of skin asse Unit Charge Nurse da redness noted on the bruise forming on the An interview conducte Nurse dated 9/14/22 had disclosed NA #2 during 2nd shift on 6/ revealed she contacte was instructed to com Resident #257, NA #7 had happened, and s immediately. NA #2 w cleaning and had not residents. The assess #257 had a quarter si	ent #257's hip not meaning both NAs rolled Resident he residents brief on, left the room. h Nurse Aide (NA) #2 was ed after several attempts. tatement dated 6/14/22 come to her last night around that NA #1 and NA #2 were ident #257 and he became thit the resident. The ealed the Unit Charge Nurse he resident immediately, Nursing (DON), and was a #1 write a statement, and liately home and that a staff contact with her the next ssment completed by the ated 6/13/22 revealed resident's chest and a right hand. ed with the Unit Charge at 3:24 PM revealed NA #1 hit Resident #257 on the hip 13/22. The Nurse further ed the DON immediately and uplete an assessment on 1 write a statement on what end NA #2 home vas in the shower room worked with any other sment revealed Resident ze bruise forming on his	F	607	7		
		ze bruise forming on his t show any kind of emotions					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 11/07/2022 ORM APPROVED 3 NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345246	B. WING				09/20/2022
	ROVIDER OR SUPPLIER	EHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET STREET GRANITE FALLS, NC 28630	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 607	incident. She reveale Resident #257 numer could be combative s indicated the NAs har anytime Resident #29 became combative to they are calm, or get complete care. An interview conduct Nursing (DON) on 9/7 she believed NA #1 v #2 and is the reason stop NA #2. The DON investigation and did state, adult protective enforcement within tv she had spoken to lar but a report was not made she was not aware the had to be sent in with further revealed she l report the incident. The expected for nursing any abuse and to rep management. An interview conduct 9/14/22 at 5:55 PM re 24 hours to send the once the incident har Administrator further contacted law enforce speaking to their corp report was not made.	or angry. The Nurse 257 was unable to recall the d both NAs had worked with rous times and knew he cometimes. The Nurse also d been educated that 57 or an aggressive resident o either walk away, wait till another employee to ed with the Director of 14/22 at 4:00 PM revealed vas upset and scared of NA NA #1 did not intervene to N completed the initial not complete a report to the e services, or law vo hours. The DON stated w enforcement the next day, made. The DON indicated at the initial intake report in two hours. The DON believed to have 24 hours to he DON revealed she staff to intervene and stop ort immediately to upper	F	607			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345246	B. WING				C 20/2022
NAME OF P	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
HICKORY	FALLS HEALTH AND RE	HABILITATION			100 SUNSET STREET GRANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	not aware the facility Administrator expected stop any kind of abus upset and scared of r The Administrator wa jeopardy on 9/15/22 a provided the following immediate jeopardy r The corrective action On 6/13/22, the Direct Administrative Nurse 100% of all in house r signs of abuse, as all to be affected. This su 6/14/22, approximate concerns were identif On 6/14/22, the Social interviewed all in-hou residents with a BIMS no allegations of abus residents verbalized of Nurse #1 began abus #1 immediately after r Nursing and Administ with Nurse Aide #2 to policy, prevention, pro- dealing with residents in long term care. Nur other staff in the facili prevention, protecting providing care for res- behaviors in long term	needed too. The ed for staff to intervene and e, but felt like NA #1 was etaliation from NA #2. s notified of immediate at 9:00 AM. The facility g credible allegation of emoval. plan was as followed: tor of Nursing and initiated a skin sweep on residents assessing for any residents have the potential weep was completed on ly at 3:00am. No additional fied. al Worker and Administrator se alert and oriented S of 10 or higher, to ensure se were reported. No concerns. se in-servicing to Nurse Aide notifying the Director of rator of the alleged event reeducate on the abuse potecting and reporting, and s with aggressive behaviors rse #1 then in-serviced all ty on the abuse policy, g and reporting, and idents with aggressive in care. This education witness to abuse and when	F	607			

Facility ID: 923052

If continuation sheet Page 19 of 35

		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/07/2022 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345246	B. WING _			_		C 20/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HICKORY	FALLS HEALTH AND RE	HABILITATION		10	00 SUNSET STREET			
				G	RANITE FALLS, NC 28	8630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page prevention, and de-ess Nursing and the Admi facility at approximate investigation of abuse policy, prevention, pro- dealing with residents in long term care to al 6/15/22. Any staff not be allowed to work un On 9-15-22, all facility the education provide reports abuse, what to abuse, and when to re- identified. The Regional Operati Administrator and the 6-21-22 on the abuse protecting residents, s abuse to include repor Personnel Registry ar 2 hours of an abuse all As of 6-21-22, the Re- and/or the Regional C all reportable allegatio reporting to the State as required by the reg- there is no failure for to allegation to a nurse, Any issues identified of process will addressed	 19 calation. The Director of nistrator arrived at the dy 11pm to continue with the e. Education on the abuse otecting and reporting, and with aggressive behaviors I staff was completed on educated by 6/15/22 will not til education is completed. staff were interviewed on d on What is abuse, who do if you witness an eport abuse. No issues were ons Manager educated the Director of Nursing on policy, prevention of abuse, staff & visitors, and reporting rting to The Healthcare and Police Department within illegation. gional Operations Manager Clinical Manager will review ons to ensure timely Agency and other officials pulation, and to ensure that timely reporting an supervisor, or Administrator. during this monitoring d promptly. On 9-17-22, 	F	607				
	reporting to APS. The Director of Nursing or reporting to APS.	trator on the requirement for Administrator educated the						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		345246	B. WING				20/2022
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HICKORY	FALLS HEALTH AND RE	HABILITATION			100 SUNSET STREET GRANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 607	Director of Nursing ar the re-education that 6/13/22-6/15/22 by Ac validating what is abut to do if you witness ar abuse. No issues wer Education on the abu protecting, and report with aggressive beha be provided in the mo starting July 7/13/22 I Director of Nursing to Date of Immediate Je On 9/20/22, the faciliti immediate jeopardy n was validated by the revealed they had red abuse and how to car combative residents. conducted on all resid alert and oriented res no concerns identified manager educated th abuse policy, prevent residents, staff and vi Education was receiv timely manner to agel be reviewed to ensure timely.	 e, were interviewed by the ad Nurse Administration on was provided on dministrator or designee use, who reports abuse, what a abuse, and when to report re identified. se policy, preventing, ing, and caring for residents viors in long term care will onthly All-Staff meeting by the Administrator or staff x 6 months. opardy Removal: 9-18-22 y's credible allegation for emoval effective 9/18/22 following: Staff interviews served education on resident re for aggressive and Skin assessments were dents and identified, and idents were interviewed with d. The regional operational e Administrator and DON on ion of abuse, protecting sitors, and reporting abuse ed regarding reporting in a ncies. All reportables would e that that they are reported 		607			9/20/22
	§483.20(f) Automated requirement-	data processing					

Facility ID: 923052

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	S FOR MEDICARE &	MEDICAID SERVICES		ECONSTRUCTION		O. 0938-039 E SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED		
		345246	B. WING					
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
HICKORY	FALLS HEALTH AND RE	EHABILITATION		100 SUNSET STREET GRANITE FALLS, NC 28630				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE		
F 640	§483.20(f)(1) Encodir a facility completes a facility must encode t each resident in the facility (i) Admission assessme (ii) Significant change (iv) Quarterly review a (v) A subset of items reentry, discharge, ar (vi) Background (face is no admission asses §483.20(f)(2) Transm after a facility comple a facility must be cap CMS System informa contained in the MDS standard record layou and that passes stand CMS and the State. §483.20(f)(3) Transm 14 days after a facility assessment, a facility encoded, accurate, a the CMS System, inc (i) Annual assessme (ii) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, ar (viii) Background (face assessment) (face assess	ng data. Within 7 days after resident's assessment, a he following information for acility: ment. nt updates. e in status assessments. assessments. upon a resident's transfer, nd death. e-sheet) information, if there ssment. itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident 6 in a format that conforms to uts and data dictionaries, dardized edits defined by ittal requirements. Within y completes a resident's must electronically transmit nd complete MDS data to luding the following: nent. nt. e in status assessment. tion of prior full assessment. ion of prior quarterly	F 640					

Facility ID: 923052

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		345246	B. WING _				C / 20/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	20/2022
				1(00 SUNSET STREET		
HICKORY	FALLS HEALTH AND RE	HABILITATION			GRANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 640	Continued From page does not have an adr		F	640			
	transmit data in the for for a State which has by CMS, in the forma approved by CMS. This REQUIREMENT by: Based on record revi facility failed to compl Data Set (MDS) asse discharge date for 1 of reviewed for discharg Findings included: Resident #35 was add 07/08/22. A Social Worker prog 8:00 AM noted Residen hospital on 07/31/22 a Review of Resident # revealed the last com was a quarterly dated discharge assessment During an interview of MDS Coordinator exp assessments showed dashboard to indicate was due and/or had r	e (Resident #35). mitted to the facility on ress note dated 08/02/22 at ent #35 was sent out to the and was admitted. 35's medical record pleted MDS assessment 07/26/22. There was no at completed or transmitted. n 09/14/22 at 10:54 AM, the plained typically MDS l up on their computer when an MDS assessment to been transmitted but for			F640 Encoding/Transmitting Resident Assessments CFR(s):483.20(f)(1)-(4) The facility failed to complete a discha Minimum Data Set assessment within days of the discharge date for Resider #53. On September 13th, 2022, the dischar assessment for Resident #53 was completed by the MDS Coordinator. On September 16th, 2022, the Administrator and two MDS Coordinata audited all assessments to ensure that assessments completed were electronically submitted within 14 days The two MDS Coordinators were re-educated by the Administrator on September 16th, 2022, that within 14 days the facility must electronically transmit encoded, accurate, and complete MDS	rge 14 ht ge ors t all s. days t,	
	assessment wasn't. ⁻ it was an oversight ar	nt #35's discharge MDS The MDS Coordinator stated nd should have been regulatory time frame.			data to the CMS system. To ensure Quality Assurance, the Administrator and MDS Coordinators v audit 10 resident assessments weekly		

Event ID: U6EV11

Facility ID: 923052

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		0.150.40			С
		345246	B. WING		09/20/202
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET STREET	
HICKORY	FALLS HEALTH AND RE	HABILITATION		GRANITE FALLS, NC 28630	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPL
F 640	Continued From page	<u>2</u> 23	E 64	0	
F 640	During an interview o Administrator stated s	n 09/15/22 at 7:36 PM, the she would expect for MDS ompleted and transmitted	F 64	4 weeks, then 5 resident assess week for 4 weeks, then 1 reside assessment per week for 4 wee appropriate coding and timelines transmitting. Findings from this be presented in the Quality Assu meeting for a minimum of four consecutive months.	nt ks for ss for audit will
F 641 SS=D	CFR(s): 483.20(g) §483.20(g) Accuracy		F 64	All corrective action will be comp September 20th, 2022.	pleted on 9/20/2
	resident's status. This REQUIREMENT by: Based on record revi facility failed to accura Payment System (PP (MDS) assessments i hospice, Preadmissio Review (PASRR), and 6 of 30 sampled resid #45 #44, #153, and # accuracy. Findings included: 1. Resident #79 was 01/12/22. His diagno chronic kidney diseas dialysis. A staff progress note	is not met as evidenced iew and staff interviews, the ately code the Prospective (S) and Minimum Data Set in the areas of dialysis, on Screening and Resident d activities of daily living for lents (Residents #79, #309, 65) reviewed for MDS admitted to the facility on ses included diabetes, se, and dependence on renal dated 07/09/22 written by realed Resident #79 was		F641-483.20(g) Accuracy of Assessments The facility failed to accurately of Prospective Payment System an Minimum Data Set assessments areas of dialysis, hospice, Pread Screening and Resident Review activities of daily living for Resid #309, #45, #153 and #65. On September 16th, 2022, the M Coordinators corrected the Minin Set for Residents #79, #309, #4 and #65 to accurately code in the dialysis, hospice, Preadmission and Resident Review, and activiti daily living.	nd s in the dmission , and ents #79, MDS mum Data 5, #153 e areas of Screening

Event ID: U6EV11

Facility ID: 923052

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	I E CONS	STRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			· · ·	MPLETED
							С
		345246	B. WING				09/20/2022
NAME OF P	ROVIDER OR SUPPLIER	L		STREET	TADDRESS, CITY, STATE, ZIP CODE	-	
				100 SU	NSET STREET		
HICKORY	FALLS HEALTH AND RE			GRAN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 641		- 04					
F 641	15		F 64				
	scheduled to go to dia	5			September 16th, 2022, the		
	Thursday, and Sature	days.			ministrator, Social Worker, Directo		
		1701			rsing, Assistant Director of Nursing		
		79's comprehensive care			DS Coordinators audited all Minimu	Im	
	-	evised 07/18/22, revealed			ta Sets to ensure that they were		
		or complications related to			curately coded for activities of daily		
	hemodialysis. Interve				ng (ADL), Preadmission Screening		
		mes a week as ordered on			sident Review (PASRR), hospice a		
	Tuesday, Thursday, a	and Saturday.			alysis. Any noted areas of deficience	су	
					ere corrected at the time of		
		ssment dated 08/26/22		lae	entification.		
		'9 was not coded as having			- Administrator in completed the Co		
	received dialysis serv	Aces.			e Administrator in-serviced the Soc orker and two MDS Coordinators or		
	During an interview o	on 00/14/22 at 10:32 AM tha				1	
	MDS Coordinator cor	on 09/14/22 at 10:32 AM, the			cognizing and accurately coding		
		stated it was a coding error			sidents who are receiving dialysis d/or hospice services and correct		
	•	indicated as received on the			SRR coding while completing a		
	5-day PPS assessme				nimum Data Set on September 16t	h	
	J-uay FFS assessine	ent dated 00/20/22.			22. The MDS Coordinators were	11,	
	During an interview o	on 07/01/22 at 7:40 PM, the			serviced on verifying the Nurse Aid	00	
		she would expect for PPS			cumentation regarding activities of		
		oded appropriately and			ng to ensure the Minimum Data Se		
		esident's status at the time of			is accurate by the Administrator on		
	the assessment.				ptember 16th, 2022.		
	2. Resident #309 wa	is admitted to the facility		То	ensure Quality Assurance, the		
		oses included dementia,			ministrator and/or designee will rev	/iew	
	heart failure, and diat				/linimum Data Sets per week for ei		
					eks, then 2 Minimum Data Sets pe		
	The Hospice Recertif	ication for the period		we	ek for four weeks. Findings from t	his	
	06/06/22 through 07/3	30/22 revealed Resident		au	dit will be presented in the Quality		
	#309 was admitted u	nder hospice care on		As	surance meeting for three consecu	itive	
	12/03/21 related to a			mo	onths to three months to ensure		
	Alzheimer's disease,	had a limited life expectancy		cor	ntinued compliance.		
	of 6 months or less, a	and was certified as eligible					
	for hospice care.				corrective action will be completed	l on	
				Se	ptember 20th, 2022.		

Facility ID: 923052

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CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (V) PROVIDERUBURENTILIZATION (V) PROVIDERUBURUBURUBURUBURUBURUBURUBURUBURUBURUB			ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
C 345246 B WING C 99/20/2022 INVECOF PROVIDER ON SUPPLER INVECOF SUPPLER SUPPLER INVECOF SUPPLER SUPPLEN INVECOF <	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	ECONSTRUCTION	(X3) DATE	SURVEY
346246 INVING 09/20/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE STREET ADDRESS, CITY, STATE, ZP CODE 100 SUMSET STREET GRAINE FALLS, NC 28630 COMPLICATION STREET ADDRESS, CITY, STATE, ZP CODE COMPLICATION	AND FLAN OF	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDI	NG _			
HICKORY FALLS HEALTH AND REHABILITATION 100 SUNSET STREET (W1)D, WEEK, Control (Control (345246	B. WING				-
HICKORY FALLS HEALTH AND REHABILITATION GRANTEE FALLS, NC 28630 (M) ID PRETRY TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH EDICIENCY MUST BERECEDED BY FULL RESULATORY OR LSC IDENTFYING INFORMATION) ID PRETRY TAG PROVIDENT OF CORRECTION SHOULD B (EACH EDICIENCY MUST BERECEDED BY FULL RESULATORY OR LSC IDENTFYING INFORMATION) PROVIDENT TAG PROVIDENT (EACH EDICIENCY MUST BERECEDED BY FULL RESULATORY OR LSC IDENTFYING INFORMATION) PROVIDENT TAG PROVIDENT (EACH EDICIENCY) (PO) (EACH EDICIENCY) F 641 Continued From page 25 revealed Resident #309 was not coded as having a prognosis that might result in a life expectancy of less than 6 months and receiving hospice care. F 641 During an interview on 09/14/22 at 10:32 AM, the MDS Coordinator confirmed Resident #309 received hospice services. The MDS Coordinator revealed she did not code hospice services or prognosis of life expectancy of less than 6 months on the MDS assessment because he was currently listed as private pay. She explained Resident #309 admitted to the facility with a Medicare replacement as his payor source then would become the payor source. During an interview on 07/01/22 at 7:40 PM, the Administrator stated she would expect for MDS assessment. S. Resident #45 was admitted to the facility on 03/22/22 with multiple diagnoses that included anxiety, depression, unspecified mood disorder, and dementia with behavioral disturbance. A Preadmission Screening and Resident Review (PASRR) Level II Determination Letter dated 05/23/19 Indicated Resident Review II Heat Hill Determination Letter dated 05/23/19 Indicated Resident Review II	NAME OF PI	ROVIDER OR SUPPLIER						
PREFix TAG CECH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFix TAG CECH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY) F 641 Continued From page 25 revealed Resident #309 was not coded as having a prognosis that might result in a life expectancy of less than 6 months and receiving hospice care. F 641 During an interview on 09/14/22 at 10:32 AM, the MDS Coordinator confirmed Resident #309 received hospice services. The MDS Coordinator revealed she did not code hospice services or prognosis of life expectancy of less than 6 months on the MDS assessment because he was currently listed as private pay. She explained Resident #309 admitted to the facility with a Medicare replacement as his payor source then went to private pay due to having to spend down before he qualified for Medicaid. She added, once he became eligible for Medicaid hospice would become the payor source. During an interview on 07/01/22 at 7:40 PM, the Administrator stated she would expect for MDS assessments. 3. Resident #45 was admitted to the facility on 03/22/22 with multiple diagnoses that included anxiety, depression, unspecified mood disorder, and dementia with behavioral disturbance. A Preadmission Screening and Resident Review (PASRR) Level II Determination Letter dated 05/23/19 indicated Resident #45 had a Level II	HICKORY	FALLS HEALTH AND RE	HABILITATION					
revealed Resident #309 was not coded as having a prognosis that might result in a life expectancy of less than 6 months and receiving hospice care. During an interview on 09/14/22 at 10:32 AM, the MDS Coordinator confirmed Resident #309 received hospice services. The MDS Coordinator revealed she did not code hospice services or prognosis of life expectancy of less than 6 months on the MDS assessment because he was currently listed as private pay. She explained Resident #309 admitted to the facility with a Medicare replacement as his payor source then went to private pay due to having to spend down before he qualified for Medicaid. She added, once he became eligible for Medicaid hospice would become the payor source. During an interview on 07/01/22 at 7:40 PM, the Administrator stated she would expect for MDS assessments to be coded appropriately and accurately reflect a resident's status at the time of the assessment. 3. Resident #45 was admitted to the facility on 03/22/22 with multiple diagnoses that included anxiety, depression, unspecified mood disorder, and dementia with behavioral disturbance. A Preadmission Screening and Resident Review (PASRR) Level II Determination Letter dated 05/23/19 indicated Resident #45 had a Level II	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
date. Review of the North Carolina Skilled Nursing Facility PASRR authorization codes document revealed a PASRR ending in "C" indicated "Level II: no end date, no limitation unless change in	F 641	revealed Resident #3 a prognosis that migh of less than 6 months During an interview of MDS Coordinator com received hospice serve revealed she did not of prognosis of life exper- months on the MDS a currently listed as priv Resident #309 admitt Medicare replacement went to private pay du before he qualified for once he became eligi would become the par During an interview of Administrator stated se assessments to be co- accurately reflect a re- the assessment. 3. Resident #45 was 03/22/22 with multiple anxiety, depression, u and dementia with be A Preadmission Screet (PASRR) Level II Det 05/23/19 indicated Re- PASSR that ended in date. Review of the North O Facility PASRR author revealed a PASRR er	09 was not coded as having thresult in a life expectancy and receiving hospice care. In 09/14/22 at 10:32 AM, the firmed Resident #309 vices. The MDS Coordinator code hospice services or ctancy of less than 6 assessment because he was vate pay. She explained ed to the facility with a that as his payor source then use to having to spend down r Medicaid. She added, ble for Medicaid hospice yor source. In 07/01/22 at 7:40 PM, the she would expect for MDS oded appropriately and esident's status at the time of admitted to the facility on e diagnoses that included unspecified mood disorder, havioral disturbance. ening and Resident Review ermination Letter dated esident #45 had a Level II a "C" with no expiration Carolina Skilled Nursing rization codes document hoding in "C" indicated "Level	F	641			

Facility ID: 923052

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345246	B. WING				_ 20/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKORY	FALLS HEALTH AND RE	HABILITATION			100 SUNSET STREET GRANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 641	 condition, specialized The annual MDS date Resident #45 was not state Level II PASRR mental illness and/or During interviews on 0 11:57 AM, the MDS C they reviewed Reside via the North Carolina Screening Tool (NC M as "no" under the colu MDS Coordinator state instructed, Resident # the criteria and did not Level II PASRR on the 04/18/22. During an interview of Administrator stated is assessments to be con accurately reflect a react the assessment. 4. Resident #44 was a diagnoses which inclu of the bone), muscle muscle weakness. The resident was con to paraplegia. The admission Minim assessment dated 08 	services required." ed 04/18/22 revealed a currently considered by the process to have a serious intellectual disability. 09/14/22 at 10:32 AM and coordinator explained when ant #45's PASRR information a Medicaid Uniform MUST) website, it was noted umn "sent to Level II." The ted based on what she was 45's PASRR did not meet at need to be coded as a e MDS assessment dated a m 07/01/22 at 7:40 PM, the she would expect for MDS oded appropriately and sident's status at the time of admitted on 07/29/22 with uded osteomyelitis (infection wasting and atrophy and fined to his wheelchair due um Data Set (MDS) /05/22 indicated Resident a room once with minimal	F	641			

Facility ID: 923052

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED C	
		345246	B. WING	B. WING		09/20/2022	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKORY	FALLS HEALTH AND RE	HABILITATION			00 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 PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	An interview with the 09/15/22 at 2:38 PM r paraplegic and was n with assistance and th coding the MDS. She information on the ass populated from docum Aides (NAs) but said th have caught the error stated the assessmen corrected. An interview with the on 09/15/22 at 6:29 P on the Activities of Da assessment automatii documentation of the nurses should verify th prior to signing off on An interview with the A 7:40 PM revealed sor MDS assessment automatic longer going to auto-p documentation but rat according to the resid assessment to ensure 5. Resident #153 was diagnoses which inclu ankle, arterial ulcers, diabetic foot ulcer on Review of Resident #	MDS Coordinator on revealed Resident #44 was of able to walk on his own or his had been an error in e explained some of the sessment automatically nentation by the Nurse the MDS nurses should . The MDS Coordinator it would be modified and Director of Nursing (DON) M revealed the information ily Living on the MDS cally populated from NAs but said the MDS he information as correct the assessment. Administrator on 09/15/22 at ne of the information on the omatically populated from on. She stated they were no oppulate that section from ther were going to code it ent at the time of the e the MDS was accurate. admitted on 09/01/22 with ided osteomyelitis of right diabetes mellitus and the left foot. 153 ' s physician orders led he was non-weight wer extremities.	F	541			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345246	B. WING				C 20/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				1	100 SUNSET STREET			
HICKORY	FALLS HEALTH AND RE	HABILITATION		Ģ	GRANITE FALLS, NC 28630			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 641	 #153 had walked in h had walked in the corminimal assistance for indicated Resident #1 sides of his lower extr An interview with the 09/15/22 at 2:38 PM n non-weight bearing at his own or with assist error in coding the ME the information on the populated from docur Aides (NAs) but said have caught the error stated the assessmen corrected. An interview with the on 09/15/22 at 6:29 P on the Activities of Da assessment automati documentation of the nurses should verify t prior to signing off on An interview with the A 7:40 PM revealed sor MDS assessment automati longer going to auto-p documentation but rai according to the resid assessment to ensure Resident #65 was a diagnoses which inclu 	 //08/22 indicated Resident is room independently and ridor at least once with om staff. The MDS further 153 had impairment on both remities. MDS Coordinator on revealed Resident #153 was not able to walk on ance and this had been an DS. She explained some of e assessment automatically mentation by the Nurse the MDS nurses should 5. The MDS Coordinator not would be modified and Director of Nursing (DON) M revealed the information ally Living on the MDS cally populated from NAs but said the MDS he information as correct the assessment. Administrator on 09/15/22 at me of the information on the tomatically populated from on. She stated they were no populate that section from ther were going to code it lent at the time of the e the MDS was accurate. 	F	641				
	6. Resident #65 was a diagnoses which inclu	admitted on 08/17/22 with						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF DI AND PLAN OF COF	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	
		345246	B. WING				20/2022
NAME OF PROVI	DER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
HICKORY FAL	LS HEALTH AND RE	HABILITATION			100 SUNSET STREET GRANITE FALLS, NC 28630		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
dishe he Th of Th as #6 ph An 09 inc thi ex as do the Th wo An on on as do nu pri An 7:2 MI the lor do ac	aling. le resident was able her meals. le admission Minimu- sessment dated 08, 5 required supervis ysical assistance w interview with the I /15/22 at 2:38 PM r dependent with eating s had been an error plained some of the sessment automatic cumentation by the MDS nurses shou le MDS Coordinator buld be modified and interview with the I 09/15/22 at 6:29 Pl the Activities of Da sessment automatic cumentation of the rses should verify th or to signing off on a interview with the A 40 PM revealed som DS assessment automatic e NAs documentation but rat cording to the reside	ight femur with routine to feed herself with set up um Data Set (MDS) (24/22 indicated Resident ion from 2 or more staff ith eating. MDS Coordinator on evealed Resident #65 was ng after being set up and in coding the MDS. She information on the cally populated from Nurse Aides (NAs) but said Id have caught the error. is stated the assessment d corrected. Director of Nursing (DON) M revealed the information ily Living on the MDS cally populated from NAs but said the MDS he information as correct	F	64			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/07/2022 MAPPROVED D. 0938-0391	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
		345246	B. WING			C 09/20/2022		
NAME OF PF	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HICKORY	FALLS HEALTH AND RE	EHABILITATION			00 SUNSET STREET GRANITE FALLS, NC 28630			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 761	Continued From page	e 30	│ F	761				
F 761 SS=D	Label/Store Drugs an CFR(s): 483.45(g)(h)		F	761			9/20/22	
	Drugs and biologicals	y and cautionary						
	§483.45(h) Storage of Drugs and Biologicals							
	Federal laws, the faci biologicals in locked of	ordance with State and ility must store all drugs and compartments under proper , and permit only authorized cess to the keys.						
	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced							
	by: Based on observatio facility failed to discar	y: Based on observation and staff interviews, the Icility failed to discard an expired medication vailable for use in 1 of 5 medication carts (F hall			F761 Label/Store Drugs and Biologic CFR(s):483.45(g)(h)(1)(2) On September 14th, 2022, the facility failed to discard an expired bottle of			
	The findings included	Ŀ			Thera-tabs off the F hall medication c	art.		
		F hall medication cart on vith Medication Aide (MA) #1			On September 14th, 2022, the facility discarded the expired bottle of Thera-			

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION	(X3) DA	10. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:	· /	<u> </u>	· · · ·	MPLETED		
						С		
		345246	B. WING			9/20/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE			
HICKORY	FALLS HEALTH AND F	REHABILITATION		100 SUNSET STREET				
				GRANITE FALLS, NC 28630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
F 761	Continued From pag	ge 31	F 76	51				
		ened bottle of Thera-tabs full of oblong-shaped		from the medication cart	t.			
	reddish-brown table	ts. (Thera-tabs is a		On September 14th, 202				
		n product used to treat or		Nursing and Assistant D	•			
		ciency.) The bottle was		checked all five medicat				
		by date of 11/21. (Best by /hich the manufacturer can		ensure that all carts wer	e free from			
		Ill potency and safety of the		expired medications.				
	drug.)	in potency and safety of the		The Director of Nursing	and Assistant			
				Director of Nursing was				
	An interview with M	A #1 on 9/14/22 at 6:40 AM		Administrator on ensurir	ng that all			
		ot sure if any of the residents		medication carts are free	-			
		ra-tabs, but she didn't give it		medications on Septem				
	-	nts on her shift. MA #1 stated		All nurses and medication				
	-	e bottle of Thera-tabs to prop s in the narcotic drawer. MA		re-educated by the Direct and/or designee by Sep				
	-	he bottle did not need to be		2022, that all medication				
		ation cart and that it needed		free from expired medica				
	to be disposed of.			they must check the me each shift.				
		e Director of Nursing (DON)						
		M revealed she had just		To ensure Quality Assur				
		f an expired bottle of ed to hold up the narcotic		medication carts will be per week four four week				
		nedication cart. The DON		medication carts are free				
		d medication aides who		medications by the Direct				
		cation carts were responsible		and/or designee, therea	-			
		es on the medications and		carts per week for four v	veeks, and then 1			
		were expired. She also stated		medication cart per wee				
		le of Thera-tabs should not		The Administrator will au				
		dication cart and should have en it went out of date.		carts per week for four w				
				1 medication cart per we weeks. Findings from the				
				presented to the Quality				
				meeting for four consecu				
				All corrective action will	be completed on			

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	5 FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT			OMB NC (X3) DATE	0. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	, í	A. BUILDING			LETED	
		345246	B. WING			C 09/20/2022		
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
HICKORY	FALLS HEALTH AND RI	EHABILITATION			SUNSET STREET ANITE FALLS, NC 28630	30		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 867	Continued From page	e 32	F	367				
F 867 SS=D	QAPI/QAA Improvem CFR(s): 483.75(g)(2)	nent Activities		367			9/21/22	
	§483.75(g) Quality as	ssessment and assurance.						
	§483.75(g)(2) The quality assessment and assurance committee must:							
	action to correct iden	ement appropriate plans of tified quality deficiencies; Γ is not met as evidenced						
	by: Based on observatio	ons, record reviews and 's Quality Assessment and			F867 QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	S		
		mmittee failed to maintain			Gr ((3): 400.70(g)(2)(ii)			
	implemented procedu				The facility Quality Assurance Committe			
		committee put into place on			failed to mention implemented procedur			
		used Infection Control and on survey completed on			and monitor the interventions the facility out into place following the COVID-19	/		
	11/19/2020 and the r				Focused Infection Control and complain	nt		
		1. This was for two repeated			investigation survey on 11/19/20 and	it.		
		eas of labeling and storage			recertification survey completed on			
		als and freedom from abuse			5/20/21 in the areas of labeling and			
	the current recertifica	areas were cited again on ation survey with an exit date continued failure of the			storage of drugs and biologicals and freedom from abuse and neglect.			
	facility during the thre	ee federal surveys shows a			A plan of correction for F600 cited durin	g		
	pattern of the facility	s inability to sustain an			the COVID-19 Focused Infection Control			
		essment and Assurance			Survey and complaint investigation on			
	Program.			1	11/19/20 and for F761 cited during the recertification survey on 5/20/21 were			
	The findings included			1	submitted to CMS and accepted with follow up and return to compliance visits			
	This tag was cross re			t	Plans of correction were put into place a the time of each deficiency cited. Each			
		ervation and staff interviews,			plan of correction included monitoring			
		scard an expired medication			tools, and review of monitoring tools			
		of 5 medication carts (F hall			during monthly Quality Assurance	unt		
	medication cart).			(Committee meetings for a defined amou	unt		

Event ID: U6EV11

Facility ID: 923052

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		MEDICAID SERVICES			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		с
		345246	B. WING	09/20/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05/20/2022
				100 SUNSET STREET	
HICKORY	FALLS HEALTH AND R	EHABILITATION		GRANITE FALLS, NC 28630	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION (X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	B.17
F 867	Continued From page	e 33	F 86	7	
	During the recertifica	tion survey of 5/20/2021 the		correction was presented to the C	Quality
		rd an undated opened		Assurance Committee and no fur	
		uenza vaccine in 1 of 1		issues were identified throughout	the
	medication room, dis	card an opened single-dose		monitoring period and were disco	
	-	nedication, undated and			
		and loose pills in 5 of 5		The Administrator initiated an in-s	
	,	all, B hall, C hall, D hall and		all administrative staff on Septem	
		ed to store undated and		2022, regarding Quality Assurance	
	-	sulin per manufacturer		Performance Improvement proce	
		d to secure a narcotics		including identifying and prioritizir	
	drawer in 1 of 5 med	ication carts.		deficiencies, systemically analyzin	
	F- 600: Based on rec	ord roviow and staff		causes of systemic quality deficie developing, and implementing co	
		failed to protect a resident		action or performance improvement	
	-	sical abuse when Nurse Aide		activities, and monitoring and eva	
		p provide care to a resident		the effectiveness of corrective	liading
		e he was agitated and		action/performance improvement	
	· · · ·	unted, aggressively pushed,		activities. This in-service include	
		slapped the resident on the		ensuring accuracy of audits, exte	
		arms and held them on his		audits when appropriate, and revi	-
		resident asking, "are you		corrective action/performance	•
		and leaving a bruise on his		improvement activities to evaluate	e the
		ss to his chest for 1 of 3		effectiveness of each plan and re	
	residents reviewed for	or abuse (Resident #257).		necessary. All newly hired admin	istrative
				staff will receive the appropriate e	
	-	Focused Infection Control		during orientation. No Administra	
		t investigation survey		will work until they have received	the
		2020, the facility failed to		appropriate education.	
		th the required level of staff			4h a
		ult, the resident was unable		The QAPI Committee will review	
		t during the transfer and fell.		compliance audits for F600 and F	
		rted to the assigned nurse, r administration; the resident		evaluate continued compliance.	
		ssessed after the fall and the		any noncompliance is identified a	
		ited in the medical record. A		reevaluate the plan of correction f	
		resident complained of pain		possible revisions. This process	
		d a fracture of the outer layer		continue until the facility has achieved	
		ve the knee joint on the right		three months of consistent compl	
		f 3 sampled residents for			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/07/2022 APPROVED D: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				LETED
		345246	B. WING				C 20/2022
NAME OF PI	ROVIDER OR SUPPLIER		I	ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
HICKORY	FALLS HEALTH AND RE	HABILITATION			00 SUNSET STREET RANITE FALLS, NC 28630		
		ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	IX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	COMPLETION DATE
F 867	Continued From page	34	Í F	867			
	provide supervision to	prevent accidents.			The Administrator will be responsible the plan of correction.	or	
	An interview was conducted on 09/15/22 at 7:35 PM with the Administrator who also headed the QAA committee. The Administrator stated the facility had completed medicine cart audits by the Administrator, nurses, and pharmacist after the last recertification, discussed medicine storage frequently at quarterly QAA meetings, and had staff complete in-service and education on medicine storage. The Administrator further revealed she could did not know why medicine storage had been an issue again but indicated one on one training would be completed with staff.				the plan of correction. Date of compliance: September 21st, 2022		
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: U6E	EV11	Fac	ility ID: 923052 If contir	uation shee	t Page 35 of 35