STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	C 05/21/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 05/18/2025 through 05/21/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 21Z611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/18/2025 through 05/21/2025. Event ID# 21Z611. The following intake was investigated NC00228902 Please select one of the followings: 1 of the 4 complaint allegations resulted in deficiency.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		5/23/25

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

Electronically Signed | 06/09/2025

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F 842	Continued From page 1 (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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F 842	Continued From page 2 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner and Medical Director interviews, the facility failed to maintain a complete and accurate medical record when identification of a new pressure injury and the completion of wound treatments were not documented in the medical record for 1 of 3 residents reviewed for accurate medical record (Resident #303). The findings included: Resident #303 was admitted to the facility on 1/7/2021. A physician's order dated 1/3/2025 read: "Cleanse sacrum with wound cleanser, pat dry, apply betadine and secure with foam patch once a day" was written by the Wound Nurse. Review of the medical record revealed no documentation regarding a change in Resident #303's skin integrity on 1/3/2025. A physician's order dated 1/15/2025 that read "cleanse sacrum with wound cleanser, pat dry, apply calcium alginate and secure with foam patch once a day. Review of Resident #303's January Treatment Administration Record (TAR) revealed there were	F 842	F842 The facility failed to maintain a complete and accurate medical record when documentation of a newly identified pressure injury and completion of wound treatments was missing for resident #303. The Director of Nursing immediately provided education to the Treatment Nurse on proper documentation procedures, specifically the requirement to document all wound treatments in the Medication Administration Record (MAR) and Treatment Administration Record (TAR), and also the requirement to document wound measurements, condition, and to document the notification of the responsible party on 5/21/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with wounds are at risk for the deficient practice. On 5/21/25, all residents in the building had their skin assessed for new wounds. No new wounds identified.	

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F 842	Continued From page 3 two days when ordered treatments had no documentation on the TAR (1/16/2025 and 1/17/2025) and four days documented as "not administered other" (1/6/2025, 1/8/2025, 1/13/2025, and 1/24/2025). During a telephone interview on 05/21/25 8:35 AM NA #2 stated she was familiar with Resident #303. NA #2 stated Resident #303 had frequent loose bowel movements and redness to her bottom and a barrier cream was applied. NA # 2 stated she remembered reporting a new skin issue for Resident #303 to the Wound Nurse on 1/3/2025, but did not recall what the skin issue was. NA #2 explained if she reported it to the Wound Nurse, it would have been more than redness because that is why the barrier cream was applied. During an interview on 5/20/2025 at 2:59 PM the Wound Nurse stated she was notified of a new skin issue for Resident #303 on 1/3/2025. The Wound Nurse stated she assessed Resident #303 and must have seen a dark purple spot on Resident #303's sacrum since the order that was obtained was for betadine and a cover dressing, which is the treatment normally utilized for deep tissue injury wounds. The Wound Nurse stated she measured the area, obtained an order for treatment and notified the MDS department so the care plan would be updated. The Wound Nurse stated she did not know why she did not document the new pressure injury for Resident #303 on 1/3/2025 and stated she normally documents new skin issues. The Wound Nurse verified the documentation on Resident #303's TAR showed no treatment completed on 1/16/2025 and 1/17/2025, and documentation on 1/6/2025, 1/8/2025, 1/13/2025 and 1/24/2025 that	F 842	On 5/21/2025, the Director of Nursing conducted an audit of the MARS TARS to identify any missing entries. No issues were found. On 5/21/25 an ad hoc QAPI meeting was held to discuss the deficient practice and implement a plan of correction that includes audits. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 5/21/2025, the DON and the Staff Development Nurse conducted in-service training for all licensed nurses and medication aides on proper documentation practices in the MAR and TAR, and also the requirement to document wound measurements, condition, and to document the notification of the responsible party. Emphasis was placed on ensuring that all administered medications and treatments are accurately recorded. On 5/21/25 the DON was notified by the Administrator she would be responsible for ensuring all licensed nursing staff and medication aides received the above training before working their next shift. She was also informed that the education would be added to the new hire education with no new staff working until it has been completed. Indicate how the facility plans to monitor	

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F 842	Continued From page 4 revealed the ordered treatment was documented and "not administered other". The wound nurse stated if she was working the treatments were completed, but she may not have signed the TAR. The wound nurse stated she is normally in the facility until around 4:45 PM but the treatment orders show on the electronic medication administration record as late after 3:00 PM and sometimes the second shift nurses sign it off as not administered to remove it from their screen. Review of the facility's daily staffing sheets from January 2025 revealed the wound nurse was scheduled on 1/6/2025, 1/8/2025, 1/13/2025, 1/16/2025, 1/17/2025, and 1/24/2025. During a telephone interview with Nurse #2 she verified when she signed "not administered other" on 1/8/2025, 1/13/2025 and 1/24/2025 she had not completed the treatment because it was ordered for 1st shift and showing not completed on her screen. During an interview on 5/20/2025 at 4:45 PM the Nurse Practitioner (NP) stated a new skin issue should be documented in the medical record when it was discovered. During a telephone interview on 5/21/2025 at 8:19 AM the Medical Director stated he would expect the nurses to complete documentation to the best of their ability when a new pressure injury was identified. The Medical Director stated he expected ordered treatments be documented accurately to the best ability of the nurse. During an interview with the Director of Nursing (DON) on 5/20/2025 at 4:35 PM the DON stated she expected the TAR to be completed accurately	F 842	its performance to make sure solutions are sustained: The Director of Nursing or designee will conduct audits five days per week to monitor for incomplete or missing entries in the MAR and TAR, verify that any orders related to skin issues are documented in the medical record, and verify that the responsible party was notified. Any discrepancies will be addressed through immediate education with the staff involved. This monitoring process will continue for a period of three months. The Administrator will oversee the implementation of this Plan of Correction and will present audit findings at the Quality Assurance and Performance Improvement (QAPI) meetings for three consecutive sessions. After this period, the committee will determine if continued monitoring is needed. If compliance is not sustained, the Plan of Correction will be revised to include additional education and oversight as necessary to achieve and maintain regulatory compliance. Date of compliance is: 05/23/2025	

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F 842	Continued From page 5 and for documentation to reflect care provided. During an interview on 5/21/2025 at 10:03 AM the Administrator stated he expected for the medical record documentation to be complete and accurate.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		5/23/25

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F 880	Continued From page 6 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to clean and disinfect an individually assigned glucometer per	F 880	Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 880	Continued From page 7 manufacturer recommendations and the facility also failed to follow their infection control policy when staff wore a torn glove during blood glucose check for 1 of 3 staff observed during blood glucose monitoring (Nurse #3). Findings included: A review of facility policy entitled "Blood Glucose Monitoring" last updated 01/02/25 stated "the nurse will abide by the infection control practices of cleaning and disinfection of the glucometer as per the manufacturer's instructions and in accordance with the facility's glucometer disinfection policy. Individual glucometers for residents must have proper identification to distinguish between residents and these should not be shared between residents". A review of facility policy entitled "Personal Protective Equipment" last updated 01/02/25 under section "indications/consideration for PPE - gloves" stated "change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn". A review of the manufacturer's cleaning and disinfection procedure guide, the glucometer should be cleaned with an Environmental Protection Act (EPA) approved disinfectant after use on each patient. Hand sanitizing wipes were not listed as an appropriate disinfectant for glucometers on the manufacture's guide. Super Sani-cloth Germicidal disposable wipes were listed as an approved disinfectant on the manufacturer's cleaning instructions, and the facility had these wipes available on the medication cart.	F 880	practice: The facility failed to disinfect an individually assigned glucometer according to manufacturer guidelines and did not adhere to its own infection control policy when a staff member was observed wearing a torn glove during a blood glucose check. On 5/19/25 following notification by the surveyor, Nurse #3 was immediately re-educated by the Director of Nursing on proper glucometer disinfection procedures in accordance with the manufacturer's instructions, and on the requirement that personal protective equipment (PPE) must be intact prior to providing resident care. The glucometer in question was immediately re-cleaned per manufacturer instructions. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. On 5/19/25, the Unit Manager conducted an audit to observe staff for proper infection control practices related to glucometer cleaning and PPE use. No deficiencies were identified during the audit. On 5/19/25 the Director of Nursing and the Staff Development Nurse cleaned all resident glucometers per the manufacturer instructions.	

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F 880	Continued From page 8 An observation of Nurse #3 who performed blood glucose check on Resident #109 on 05/19/25 at 11:57 AM revealed that Nurse #3 obtained Resident #109's glucometer from the drawer on medication cart. Glucometer was stored in the protective case labeled with Resident #109's name. Nurse #3 then cleaned the individually assigned glucometer with alcohol-based hand disinfectant wipes prior to use. She was observed applying gloves and the glove on left hand was torn over the entire palm area. She entered the room to check Resident #109's blood glucose level. Blood glucose check was performed while Nurse #3 wore the torn glove. An error message on glucometer indicated insufficient sample and she was not able to obtain glucose level on the first attempt. Nurse #3 wore the same torn glove to obtain a new glucometer test strip out of container to recheck blood glucose a second time. She then performed the blood glucose check again. Nurse #3 was able to obtain blood glucose level on second attempt. The glove remained torn during both blood glucose checks. She removed the torn, used gloves after completion of procedure and disposed of them in the trash. She then cleaned the glucometer with the alcohol-based hand disinfectant wipes after use. The glucometer was returned to the individual case labeled with Resident #109's name and stored in the drawer in the medication cart. During an interview with Nurse #3 on 05/19/25 at 12:11 PM she stated that she was not aware that her glove was torn during the blood glucose check. She stated that her understanding of the disinfection of glucometers was to use "sani" wipes and the disinfecting hand wipes say "sani"	F 880	On 5/19/25 an ad hoc QAPI was held to discuss the deficient practice and implement a plan of correction with auditing tools. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: An inservice was initiated on 5/19/25 through 5/23/25 by the Director of Nursing (DON) for all licensed nursing staff, focusing on: • Proper cleaning and disinfection of glucometers as per manufacturer instructions • Routine inspection and use of PPE that is free of rips, holes, or tears Staff members who did not complete this in-service by 5/23/25 were not permitted to work until training was completed. Additionally, starting 5/26/25, this education has been incorporated into the general orientation for all newly hired nursing staff. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The Director of Nursing or designee will conduct a weekly audit of 5 observations of nurses disinfecting glucometers in accordance with manufacturer guidelines. Additionally, observation and use of PPE	

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F 880	Continued From page 9 on them, so she thought that was sufficient. She stated she thought the disinfectant hand wipes were adequate and she was not familiar with the manufacturer's glucometer disinfection recommendations. An interview with the Director of Nursing on 05/19/25 at 1:06 PM revealed that the expectation was for the facility's blood glucose monitoring policy to be implemented during blood glucose checks. Intact gloves were to be worn during the procedure. Her expectation would be that the nurse would stop and change out glove if torn or damaged. According to the manufacturer's directions, alcohol-based hand disinfectant wipes were not approved to disinfect the glucometer and purple top disinfectant wipes were to be used.	F 880	that is free of rips, holes, or tears will be conducted simultaneously. Any variances will be addressed at that time. This audit will be conducted for 4 weeks, biweekly for a month and then once a month for one month. The Administrator will report on this Plan of Correction (POC) to Quality Assurance Performance Improvement (QAPI) committee for three consecutive meetings until the POC is completed. Recommendations for changes to the POC will occur if the facility does not maintain compliance with regulatory requirements. The POC can be changed to include additional education and monitoring to obtain and maintain substantial compliance. The plan of correction was completed 5/23/25.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345246	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 5/21/2025

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 580	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff and the Responsible Party, Wound Nurse and the Medical Director, the facility failed to notify the Responsible Party of a new deep tissue injury for 1 of 3 residents reviewed for notification of changes (Resident #303). The findings included: Resident #303 was admitted to the facility on 1/7/2021 with diagnoses that included abnormalities of gait and mobility, unsteadiness on feet, altered mental status, cognitive communication deficit, hemiplegia (muscle weakness or paralysis on one side of the body that can affect the arms, legs and facial muscles) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms legs and facial muscles) following cerebral infarction, muscle wasting and atrophy.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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Resident #303's electronic medical record revealed a physician's order dated 1/3/2025 that read: "Cleanse sacrum with wound cleanser, pat dry, apply betadine and secure with foam patch once a day"

Review of Resident #303's electronic medical record revealed no nursing progress notes from 1/3/2025 that documented Responsible Party (RP) notification.

During an interview on 5/20/2025 at 9:25 AM the Wound Nurse stated she notified Resident #303's RP regarding the deep tissue injury but failed to document the notification in a progress note. The Wound Nurse stated she did not know why she did not document the notification of the RP for Resident #303 on 1/3/2025. The Wound Nurse verified there was no documentation in Resident #303's medical record that the RP had been notified of the new deep tissue injury.

During an interview on 5/20/2025 at 2:59 PM the Wound Nurse verified that a new deep tissue injury was identified on 1/3/2025 for Resident #303. The Wound Nurse stated the Wound NP was notified once the wound was opened. She added there should have been documentation in the progress notes that the RP had been notified.

During a telephone interview on 5/21/2025 at 8:19 AM the Medical Director stated he would expect the RP to be notified of a new wound when the nurse was able to make the notification.

During an interview with the Director of Nursing (DON) on 5/20/2025 at 4:35 PM the DON stated she expected RPs to be notified of new deep tissue injuries. The DON stated the notification should be documented in the electronic medical record.

Resident #303's hospital records 1/16/2025 revealed a note from the emergency department physician that read in part "on examination patient had a small dime-sized breakdown of the superficial layer of skin at the upper gluteal cleft. Family was not aware of this."

During an interview with the Responsible Party (RP) on 5/18/2025, the RP revealed the facility had not notified her of the deep tissue injury. The RP stated she became aware at the hospital on 1/16/2025.

During an interview on 5/21/2025 at 10:03 AM the Administrator stated he expected resident's RPs to be notified of changes in the residents including new deep tissue injuries and for the notification to be documented in the residents' electronic record.