STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DRIVE , STATESVILLE, North Carolina, 28677

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 03/01/26 through 03/05/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1F1E71-H1.	E0000		
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 03/01/26 through 03/05/26. The following intakes were investigated: 888388, 2587219, 2646349 and 2659735. Two (2) of the thirteen (13) complaint allegations resulted in deficiencies. Event ID #1F1E71-H1.	F0000		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered;	F0627		

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 reverse for further 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.

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

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F0627 SS = D	Continued from page 1 (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge	F0627		

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F0627 SS = D	Continued from page 2 is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.	F0627		

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F0627 SS = D	Continued from page 3 §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.	F0627		

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F0627 SS = D	Continued from page 4 (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff, and family interviews, the facility failed to have an effective discharge planning process that ensured home health services were set up prior to discharge to the community for a resident who had a wound vac (a therapeutic device that uses controlled negative pressure [suction] to accelerate the healing of acute or chronic wounds). This failure was for 1 of 4 residents reviewed for discharge (Resident #64).	F0627		

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F0627 SS = D	Continued from page 5 The findings included: Resident #64 was admitted to the facility on 09/02/25 with diagnoses that included history of sleeve gastrectomy (a common, irreversible weight-loss surgery), Surgical wound dehiscence (the partial or total separation of previously stitched surgical incision edges), encounter for surgical aftercare following surgery of the digestive system, and small bowel perforation (a life-threatening, full-thickness hole in the small intestine wall that leaks digestive contents into the abdominal cavity, causing severe abdominal pain, peritonitis, and potential septic shock). Resident #64's admission Minimum Data Set assessment dated 09/09/25 revealed Resident #64 was cognitively intact with no delusions, behaviors, rejection of care, or instances of wandering. Resident #64 was coded as independent with eating, needed supervision with oral hygiene, and limited assistance with bed mobility, transfers, personal hygiene, upper body dressing, and bathing. Resident #64 was dependent on others for toileting hygiene, lower body dressing, and putting on and taking off footwear. Resident #64 was also coded as having a recent gastrointestinal surgery that required active skilled nursing facility care and had a present surgical wound. Her goal was to discharge to the community and active discharge planning was in process. A physician order dated 09/19/25 read: wound vac dressing change every Monday, Wednesday, and Friday to abdomen. Review of the Discharge Planner's note dated 10/01/25 revealed the Discharge Planner had verified Resident #64's wound vac was to be delivered and that a referral was sent out to a home health agency that morning at 11:38 AM on 10/01/25. The note also revealed that the Discharge Planner was contacted at 4:15 PM on 10/01/25 by the home health agency who indicated they would not be able to provide services to Resident #64 due to her geographical location. The note indicated that the Discharge Planner reached out to 3 additional home health agencies on 10/01/25 that reported they too, would not be able to service Resident #64 due to her geographical location. Per Resident #64's progress notes, Resident #64 discharged home with their spouse to their private home on 10/01/25 approximately 2:45 PM. An interview with Resident #64's Family Member on 03/03/26 at 12:32 PM revealed Resident #64 had a	F0627		

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F0627 SS = D	Continued from page 6 medical procedure in her abdominal area which resulted in the placement of a wound vacuum for wound healing prior to her admission to the facility on 09/02/25. She stated that when it came time for Resident #64 to discharge home on 10/01/25, she and Resident #64's spouse worked with the Discharge Planner to facilitate Resident #64's discharge home. During the discharge planning process they (Resident #64's) family was concerned about ensuring that home health was scheduled to see Resident #64 when she returned home due to the significant abdominal wound that still required the placement of a wound vac. Resident #64's Family Member indicated the Discharge Planner reported to them on 10/01/25 that a local home health agency referral had been sent on behalf of Resident #64 and that the home health agency had agreed to see Resident #64 upon her return home. Resident #64's Family Member reported Resident #64 was discharged home on 10/01/25. Resident #64's Family Member stated Resident #64 was home for 2 days and had not heard from the home health company so Resident #64's Family Member contacted the home health company who told her they had received the referral but had denied the referral due to Resident #64 residing outside of their services area. Resident #64's Family Member reported that the home health company stated they had informed the Discharge Planner they were unable to provide their services to Resident #64 prior to Resident #64 discharging from the facility. Resident #64's Family Member stated she contacted the Discharge Planner who insisted that the home health agency had accepted the referral. Resident #64's Family Member stated Resident #64's Family member stated they requested assistance from the facility in locating another home health agency and assistance was provided; however it took approximately 3 weeks until they were able to get Resident #64 in to see a local wound care clinic who began treating the resident and provided wound care to Resident #64. Resident #64's Family Member reported during the timeframe they were trying to find wound care for Resident #64; she drove 3 hours, round trip, to provide Resident #64's wound care as she was a registered nurse and was familiar with the wound care that needed to be provided to Resident #64. Per Resident #64's Family Member, there were no ill effects during this time despite not having home health at the time and there was no decompensation of Resident #64's wound. An interview with the Discharge Planner was completed on 03/04/26 at 12:01 PM. The Discharge Planner indicated that Resident #64 had admitted to the facility for short term rehabilitation with a goal to return home with their spouse. The Discharge Planner remembered Resident #64 and stated she had sent out the	F0627		

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F0627 SS = D	Continued from page 7 home health referral to the home health agency around 11:00 AM the day of Resident #64's discharge (10/01/25) and that Resident #64 was allowed to discharge home around 2:45 PM. The Discharge Planner stated around 4:00 PM on 10/01/25 the initial home health agency contacted her and stated they were unable to provide services to Resident #64 due to her living outside of their service area. She continued, stating she immediately contacted several other home health agencies but was unsuccessful in locating one that would provide services to Resident #64 due to her geographic location. The Discharge Planner stated she struggled to find a home health agency that was willing to provide services to Resident #64 so she expanded her search to wound care clinics to provide services to the resident as a home care patient or as an outpatient. She stated she was able to locate a local wound care clinic that was close to Resident #64 who stated they would provide Resident #64 with wound care as an outpatient, but Resident 64 and her family were unwilling to consider outpatient wound care initially. She stated ultimately, Resident #64 did begin seeing the local wound care clinic as an outpatient. The Discharge Planner stated Resident #64's family member was a nurse at the local hospital, and it was her understanding that Resident #64's family member was able to provide the needed wound care to Resident #64 until they were able to get into the outpatient wound care clinic. An interview with the Former Director of Nursing via telephone was conducted on 03/05/26 at 10:39 AM. She stated she vaguely remembered the situation with Resident #64 but stated that the Discharge Planner was way more involved than she was. She stated it was her understanding that Resident #64 had been prepared to return home after a short term rehabilitation stay and that home health had supposedly been set up and verified by the Discharge Planner. She stated that shortly after Resident #64 was discharged home, the facility was notified by the original home health agency that they had not been able to accept Resident #64 as a patient due to her geographical location. The Former Director of Nursing reported she reached out to Resident #64 and her family and offered to drive to Resident #64's home and complete the wound care until home health services or a referral to a local wound care clinic could be established. She reported the family completed the wound care. The Former Director of Nursing reported approximately "a week or so" after Resident #64 discharged, the facility was able to get her admitted to a local wound care clinic as outpatient.	F0627		

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F0627 SS = D	Continued from page 8 An interview with the Administrator on 03/05/26 at 11:47 AM revealed he did not have any interactions with Resident #64's discharge situation but reported he expected his team to be aware of all plans regarding a resident's discharge, including care or services when the resident returns home before a resident was discharged from the facility.	F0627		