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 11/19/2020

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 COVID-19 focused survey was conducted onsite on 10/23/20 with exit from the facility on 10/23/20. Additional interviews and information was obtained offsite through 11/19/20. Therefore, the exit date was changed to 11/19/20. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart B-Requirements for Long Term Care facilities. Event ID# LEGS11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation was conducted onsite on 10/23/20 with exit from the facility on 10/23/20. Additional interviews and information was obtained offsite through 11/19/20. On 11/19/20 additional interviews were conducted and the exit date was changed to 11/19/20. The facility was found to be out of compliance with 42 CFR §483.80 infection control regulations and had not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. There were 14 allegations investigated and one allegation was substantiated without citation. The remaining 13 allegations were unsubstantiated. Event ID# LEGS11.	F 000		
F 600 SS=G	Free from Abuse and Neglect 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, 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	F 600		12/3/20

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

Electronically Signed | 12/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 1 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 observations, staff, resident and physician interviews and record review, the facility failed to transfer a resident with the required level of staff assistance. As a result, the resident was unable to support her weight during the transfer and fell. The fall was not reported to the assigned nurse, the next shift nurse or administration; the resident was not thoroughly assessed after the fall and the fall was not documented in the medical record. A day after the fall the resident complained of pain and an x-ray revealed a fracture of the outer layer of the femur just above the knee joint on the right leg. This was for 1 of 3 sampled residents for provide supervision to prevent accidents (Resident #5). Findings included: Resident #5 was admitted to the facility on 11/07/18 with diagnoses that included type 2 diabetes mellitus, blindness, end stage renal disease, osteopenia, history of a left fractured leg. The Minimum Data Set (MDS) dated 07/23/20 specified the resident's cognition was intact and she required extensive 2-person assistance with	F 600	The positive x-ray results were immediately called in to Kopper Duckworth, Nurse Practitioner on September 8th, 2020 by Kathy Hall, Nursing Supervisor at 7pm. Orders were obtained by Kathy Hall, Nursing Supervisor from Kopper Duckworth, Nurse Practitioner at 7:05pm on September 8th, 2020 to access pain, reposition if needed and to obtain an orthopedic consult the morning of September 9th, 2020 if the resident was stable. If the resident wasn't stable, then she was to be sent to the ER. Kathy Hall, Nursing Supervisor accessed the resident immediately for pain and repositioned her for comfort. Resident was medicated with Tylenol and refused her tramadol on September 8th, 2020 at 7:15pm. Resident also stated that she did not wish to be sent to the ER that evening. All residents were accessed for injury and pain by Kathy Hall, Nursing Supervisor on September 8th, 2020 between 7:30pm-11:30pm. Resident #5 was currently on physical	

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F 600	Continued From page 2 transfers. The MDS also specified the resident was not steady moving from seated to standing, used a wheelchair for locomotion and had not fallen since the previous assessment. A care plan was developed for Resident #5 to address her activity of daily living (ADL) deficit related to decreased functional mobility secondary to chronic illnesses. The care plan was reviewed and updated with the MDS dated 07/23/20. The care plan's interventions specified Resident #5 required two-person assistance for transfers. A nurse practitioner (NP) progress note dated 09/08/20 specified Resident #5 was seen for follow-up to recent therapy. The NP documented Resident #5 had no complaints of pain and did not express new medical concerns. A progress note made by Nurse #1 dated 09/08/20 during second shift specified Resident #5 complained of right lower leg pain. The nurse documented that Resident's leg was edematous (swollen), slightly discolored and had a positive pulse. Resident #5's vital signs were obtained and there were no irregularities noted by the nurse. Nurse #1 contacted the physician and obtained orders for an x-ray. The findings for the x-ray report dated 09/08/20 revealed moderate to severe osteoporosis (brittle bones) with a fracture of the outer layer of the femur just above the knee joint on the right leg.	F 600	therapy caseload during the time of her fall, and was re-evaluated post fall on September 9th, 2020 by Kevin Borrelli, Physical Therapist. After the evaluation, resident #5 remained a two person assist transfer. All staff was in-serviced by the Director of Nursing and Assistant Director of Nursing on September 9th, 2020 on the procedure of reporting procedures, assessment thoroughness and documentation of incidents. On September 9th, 2020 through September 11th, 2020 all staff was re-educated by the Director of Nursing and the Assistant Director of Nursing on verifying a resident's transfer status before assisting a resident by looking at their care guide which reflects the resident's care plan. The Director of Nursing and/or designee from the Nursing Administration team will audit transfer statuses to ensure the care plan is up to date and any changes are communicated with the staff. Three residents that are two-person assist will be audited daily by the Director of Nursing and/or designee from the Nursing Administration team for one month and 10% of residents for two months to ensure continued compliance with care plans. All new hires will receive education by the Director of Nursing or designee from the Nursing Administration team on reporting	

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F 600	Continued From page 3 In the same note dated 09/08/20 made by Nurse #1, the physician was notified of the x-ray results and ordered an Orthopedic consult "ASAP (As Soon As Possible)." Resident #5's family was notified of the change in condition. On 09/09/20 at 3:53 AM a progress note made by Nurse #2 revealed Resident #5 had no complaint of pain or discomfort and rested quietly in bed. The nurse documented vitals for Resident #5 and there were no irregularities noted. On 09/09/20 at 8:54 AM a progress note made by Nurse #3 revealed Resident #5 was being transported to the Emergency Department for assessment of right leg due to pain from a fall (no date specified). The Emergency Department (ED) records dated 09/09/20 were obtained and reviewed. Resident #5 was diagnosed with a fracture of the outer layer of the femur just above the knee joint on the right leg. The ED notes specified Resident #5 presented to the Emergency Department for evaluation after a fall onto her right knee approximately 3 days ago. While in the ED, an Orthopedic physician was consulted, placed Resident #5 in a long-leg splint and returned to the facility with an order to follow-up with the Orthopedic physician (no timeframe was specified). On 09/09/20 at 5:22 PM Nurse #4 documented Resident #5 returned from the ED with a splint to	F 600	procedures, assessment thoroughness and documentation of incidents; effective immediately and will be on going to ensure compliance. To ensure quality assurance, all falls will be checked by the Administrator and/or designee from the Nursing Administration team to ensure that the fall was reported in a timely manner, and if an injury occurred, that it was reported, accessed and documented correctly; daily for three months, weekly for three months and monthly for three months. All incident reports will be monitored by a member of the Nursing Administration team for appropriate assessment of the resident by the attending nurse, thoroughness of completion; including post fall notes daily for three months, weekly for three months and monthly for three months. All corrective action will be completed on September 9th, 2020.	

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F 600	Continued From page 4	F 600		

her right leg and new orders for pain medication. The note specified Resident #5 was not in distress.

On 09/10/20 Resident #5 was seen by the NP and a progress note revealed Resident #5 reported that her right leg went out from under her and she landed on her knee. Resident #5 complained that medication was not helping her pain and the NP made changes to Resident #5's pain management.

On 10/08/20 Resident #5 was seen for follow-up by the Orthopedist. The report dated 10/08/20 specified Resident #5 was seen for follow-up of non-displaced fracture of right femur near the knee cap. The physician recommended to wear the knee immobilizer brace for 2 weeks.

On 10/23/20 at 11:48 AM Nurse #5 was interviewed and explained she was assigned to Resident #5 on 09/07/20 from 7 AM to 3 PM. The nurse stated Resident #5 attended hemodialysis Monday, Wednesday and Friday and left the facility usually round 8 AM and would not return until after the 3 PM shift ended. Nurse #5 revealed on 09/07/20 she administered insulin to the Resident prior to her shower. The nurse added that she did not have any other direct contact with Resident #5 that day and was never notified of a fall. Nurse #5 stated Resident #5 was non-ambulatory and required two-person assistance with transfers.

In the same interview, Nurse #5 explained that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 5	F 600		

she was made aware "a day or two later" Resident #5 had a fractured leg from a fall in the shower on 09/07/20. The nurse stated again that she was never notified of a fall during the shift on 09/07/20.

On 10/23/20 at 11:58 AM nurse aide (NA) #1 was interviewed and explained she was the nurse aide assigned to Resident #5 on 09/07/20 on the 7 AM to 3 PM shift. However, NA#1 stated she traded showers with NA #2 and did not provide the shower for Resident #5 on 09/07/20. NA #1 stated Resident #5 was alert and oriented and required two-person extensive assistance with transfers. The NA added there had been times when she had transferred the resident with one-person assistance even though she was care planned to have two staff. She explained that on 09/07/20 she entered the shower room and observed Resident #5 on the shower room floor. The NA could not recall what position Resident #5 was in on the floor. She stated she and NA #2 assisted Resident #5 off the floor using a gait belt and Nurse #6 was in the room and held onto the wheelchair. NA #1 stated that she did not report the fall because she was not the NA caring for the resident when the fall occurred. NA #1 added that she was trained to report any fall to the assigned nurse. NA #1 also stated that Resident #5 did not complain of pain or an injury and left the facility for dialysis after the fall. NA #1 added she did not see Resident #5 the remainder of the shift on 09/07/20. NA #1 stated she worked the following day 09/08/20 and Resident #5 did not complain of pain from the fall. The NA could not remember if Resident #5 got out of bed on 09/08/20 or had to be transferred.

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	345246	A. BUILDING _____ B. WING _____	C 11/19/2020

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F 600	Continued From page 6	F 600		

On 10/26/20 at 3:38 PM nurse aide (NA) #2 was interviewed on the telephone and explained she was not assigned to Resident #5 on 09/07/20 but had agreed to shower the resident. NA #2 stated she had showered Resident #5 in the past, but it had been so long she could not recall when the last time was. The NA explained she used care plans provided to staff with care instructions about residents. She stated she did not refer to Resident #5's care plan and relied on a co-worker who informed her Resident #5 could transfer with one-person assistance. NA #2 could not recall the identity of the co-worker. She described that on 09/07/20 after showering Resident #5, she wheeled the resident toward the toilet area equipped with a grab bar on the wall. Resident #5 held on to the grab bar, stood up from the shower chair with little assistance, as the NA reached back to get the wheelchair. NA #2 stated Resident #5 said, "I gotta sit down" and the NA lowered her all the way to the floor without a "hard impact" onto her buttocks. NA #2 stated that on 09/07/20 she was not aware Resident #5 required two-person assistance with transfers.

During the same interview, NA #2 explained that once Resident #5 was on the floor Nurse #6 entered the shower room, observed Resident #5 on the floor and asked her if she was okay. According to NA #2, the resident did not complain of pain or injury from the fall. She stated she and NA #1 (who had also entered the shower room) used a gait belt to assist Resident #5 off the floor while Nurse #6 pushed the wheelchair under the resident. Approximately a half an hour to an hour after the incident, Resident #5 left for hemodialysis. NA #2 stated she did not report the

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F 600	Continued From page 7	F 600		

fall to Nurse #1 because Nurse #6 was in the room and aware of the fall.

On 10/23/20 at 2:55 PM Nurse #6 was interviewed and described on 09/07/20 around 7:30 AM she was completing a treatment, entered the showered room to dispose of soiled linens and observed Resident #5 on the floor. Nurse #6 stated she did an assessment of Resident #5 by asking her if she was okay and looked for any obvious injury. The nurse added that Resident #5 did not complain of pain or report any injury. She explained that she held the wheelchair while NA #1 and NA #2 assisted Resident #5 off the floor. Nurse #6 reported she did not notify anyone of the fall and did not document her assessment of Resident #5 because she was not the hall nurse. Nurse #6 stated once Resident #5 was off the floor, she left the shower room and proceeded with treatments.

On 10/23/20 at 4:50 PM Resident #5 was interviewed after returning from hemodialysis. Resident #5 explained she had been a resident in the facility for more than a year and felt the staff took good care of her. She added that she was blind and relied on staff to do "a lot" for her. She stated her legs had not been good for a while and it took two people to transfer her in and out of bed. Resident #5 added that everything had been going fine until last month she fell in the shower room and broke her right leg. Resident #5 recounted an incident that occurred on Monday prior to leaving for dialysis, she was showered by a nurse aide that she could not recall her name. At the completion of the shower, she wanted to be moved closer to the toilet where

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	345246	A. BUILDING _____ B. WING _____	C 11/19/2020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8	F 600		

the floor was dry to not get her socks wet. She explained she had used the wall bar many times to hold on to while staff pulled her pants up. Resident #5 stated that "for whatever reason" when she stood up her legs "gave out" and she went down on both knees. Resident #5 reported there was only one nurse aide in the shower room for the transfer but after the fall, another person entered to assist. The resident recalled she heard a "pop" in her knee but there was no immediate pain until the next day. Resident #5 stated that since her injury, she was now transferred with a mechanical lift for all transfers.

On 10/26/20 at 12:30 PM NA #3 was interviewed on the telephone and explained Resident #5 was transferred with a mechanical lift on second shift. She went on to explain that during the evening of 09/08/20 while preparing Resident #5 to be transferred with the mechanical lift, Resident #5 started crying. The NA stated she asked Resident #5 what was wrong, and the resident reported she was dropped in the shower room on 09/07/20. NA #3 and another nurse used the mechanical total lift to transfer Resident #5 to the bed and notified Nurse #1. NA #3 stated Resident #5 had always been a mechanical total lift on second shift and she was shocked to learn the resident could use her legs to stand.

On 10/26/20 at 12:24 PM the nurse practitioner (NP) was interviewed on the telephone and explained she was providing in-room assessments and on 09/08/20 when she assessed Resident #5 there was no mention of pain and/or a fall. The NP was unaware on 09/08/20 Resident #5 had fallen and stated that

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	345246	A. BUILDING _____ B. WING _____	C 11/19/2020

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F 600	Continued From page 9	F 600		

after a fall, she tried to make a note to document what she saw. The NP added that she assessed Resident #5's pain from a fracture (on 09/10/20). The NP stated she had no reason to think Resident #5 broke her leg in any other way than from the fall on 09/07/20 in the shower room. She explained the fall was a "minor thing" that didn't require surgery and the only intervention was an immobilizer.

On 10/27/20 at 11:00 AM Nurse #1 was interviewed on the telephone and explained on 09/08/20 she was notified by NA #3 that Resident #5 was complaining of pain in her right leg. The nurse stated Resident #5 reported she had fall after a shower on the previous day. Nurse #1 added she did not see documentation of a fall in the medical record but notified the on-call and obtained orders for a mobile x-ray that revealed a fracture of the right femur. The nurse also reported she had administered as needed pain medication that was effective as evidence by Resident #5 rested with her eyes closed the remainder of the shift.

On 10/23/20 at 3:22 PM the Director of Nursing (DON) was interviewed and explained Resident #5 fell on 09/07/20 in the shower room when being transferred by NA #2. The DON stated she was not made aware of the fall until the morning of 09/09/10 through a note left under her door. The DON reported Resident #5 had complained of pain during the evening shift on 09/08/20 and an x-ray revealed a fractured right femur. The DON reported Resident #5 was sent to the Emergency Department on 09/09/20 at the request of the family. She started an

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

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F 600	Continued From page 10 investigation on 09/09/10 by going to Resident #5 and asking her what had occurred. The DON reported Resident #5 told her she was in the shower room with one nurse aide who attempted a transfer her, but she fell. The DON added she spoke with NA #2 who reported Resident #5 was in a hurry and needed to use the bathroom, so she transferred the resident but had to lower the resident to the floor. The DON explained that lowering a resident to the ground was considered a fall and NA #2 failed to have a second nurse aide assist with the transfer. The DON added that NA #2 did not report the fall to the assigned nurse and there was no documentation in the medical record about the fall on 09/07/20. The DON stated it was the responsibility of NA #2 to report the fall to Nurse #5. She added that nurses are expected to complete a head to toe assessment for injury when a fall occurred and document the assessment and incident in the medical record. The DON stated that unfortunately Resident #5's nurse had not been notified of a fall which resulted in lack of documentation in the medical record. On 10/27/20 at 4:30 PM the Administrator was interviewed on the telephone and explained that after learning about the incident on 09/07/20, the facility conducted staff in-servicing about reporting falls. She reported she felt the incident was isolated and handled by nursing administration to prevent reoccurrence. She stated she did not introduce the incident into the Quality Assurance Program but intended to follow staffs' actions to ensure falls were reported.	F 600		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		12/3/20

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 §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 §483.70(e) 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 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:	F 880		

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 (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 observation, record review, staff interview, the facility failed to educate staff on the importance of preventing cross contamination by performing hand hygiene after touching a resident or an environmental surface on the New Admission Observation COVID-19 quarantine hall. The facility failed to don/doff appropriate Personal Protective Equipment (PPE) according the Center for Disease and Prevention Control (CDC) on quarantine hall for 6 of 9 sampled residents reviewed for infection control practices	F 880	All staff will perform correct hand hygiene to prevent cross contamination after resident care and environmental surface contact. All staff will wear the proper PPE (gloves, gowns, masks and goggles) on the PUI hall as indicated on the Enhanced Droplett sign. The Infection Control Specialist educated	

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 (Resident #9, #10, #12, #15, #11, and #17). These failures in infection control practices occurred during a COVID-19 pandemic. The findings included: According to guidelines published by the CDC on 04/30/20, all new admissions shall be placed on isolation observation and full PPE is required when providing care. This PPE included the use of a gown, gloves, face mask, and eye wear and indicated hand washing was needed for the first 14 days following admission for all residents who did not meet criteria to discontinue isolation in the hospital prior to admission. According to the undated facility document titled, Admissions and Readmissions indicated the facility will follow all CMS and CDC recommendations for admissions and readmissions. The document further indicated: This will include isolation with enhanced isolation precautions for a minimum of 14 days. Residents with compromised immune systems may remain in isolation for up to 20 days. At the end of the isolation period, if the resident does not present signs of COVID-19 and has not had a new positive test (based on facility testing guidelines. Residents who have tested positive in the last 3 months will not be retested and discontinuation of isolation will be based on the 14-day isolation period and asymptomatic status of COVID-19), the resident may be moved off the isolation unit to a non-isolated unit. All occupied rooms on the Isolation/COVID-19 unit will have an "ENHANCED DROPLET" isolation sign displayed outside the room, on the door or designated area for notification of precautions. This will be in effect for all residents on the designated unit,	F 880	staff on the proper PPE (gloves, gowns, mask and goggles) guidelines and handwashing procedures based on the Enhanced Droplet Precaution signage that is in place. The Infection Control Specialist and/or Wellness Coordinator will monitor staff daily on all shifts for one month and weekly for three months therefore to ensure compliance. On October 23rd, 2020 through October 26th, 2020 all staff were re-educated on preventing cross contamination by performing proper hand hygiene after resident contact and environmental contact by the Infection Control Specialist and the Wellness Coordinator. On October 23rd, 2020 through October 26th, 2020 all staff completed donning and doffing competencies by the Administrator, Director of Nursing, Infection Control Specialist and the Wellness Coordinator. The facility will protect the residents through daily monitoring of PPE (gloves, gowns, masks and goggles) donning and doffing and handwashing procedures by the Infection Control Specialist and/or for one month and weekly for three months. The Infection Control Specialist and/or Wellness Coordinator will educate all new hires on the most up to date PPE (gloves, gowns, masks and goggles) requirements and hand washing protocols; effective immediately and on going.	

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14 regardless of COVID-19 status. Notification of ISOLATION/COVID-19 unit will be designated with an "ENHANCED ISOLATION" posting outside the unit. The following observations were made on the 100 hall New Admission Observation COVID-19 quarantine hall on 10/23/20. 1 a. Resident #9 was admitted to the New Admission Observation COVID-19 quarantine hall on 10/20/20 with diagnoses that included left femur fracture and dementia. A continuous observation of the 100 hall New Admission Observation quarantine unit was made on 10/23/20 between at 07:50 AM and ended at 08:10 AM revealed Resident #9's sitting outside the door of her room in the hallway. Resident 9's door displayed signage that indicate Modified Droplet Contact Precautions which indicated gloves and hand hygiene were required when interaction occurred. Resident #9 was sitting in her wheelchair and had an overbed table placed directly in front of her. NA #4 was wearing a face mask and eye wear when she approached Resident #9 wearing a mask and eyewear then sat the meal tray on the overbed table that Resident #9 had been observed touching prior. NA #4 opened the tray items and sat the tray up for Resident #9. NA #4 was not observed performing hand hygiene before setting up of the tray or following contact with Resident #9 before she continued delivering additional trays to other residents on the unit. NA #4 proceeded to obtain an additional tray from the meal service cart. 1 b. Resident #10 was admitted to the New Admission Observation COVID-19 quarantine hall	F 880	Our Infection Control Specialist and Director of Nursing are SPICE certified since 2019 and are up to date on the current guidelines. Root cause analysis (RCA) was completed by the Administrator, Director of Nursing and the Infection Control Specialist on October 26th, 2020. Findings from the RCA were 1. Staff failed to practice proper hand hygiene 2. Staff failed to wear proper PPE according to the Enhanced Droplet sign. Administrator or designee from the Nursing Administration team will ensure adherence to the practice of proper hand hygiene and that staff is wearing the proper PPE on the PUI hall by daily audits on all shifts. The Administrator will report all findings to the QA committee monthly for four months. Corrective action will be completed by October 26th, 2020.	

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15	F 880		

on 4/30/20 with diagnoses that included acute respiratory failure with hypoxia, left and right humerus fracture, closed fracture of the right lower extremity, foreign body in the respiratory tract, systemic inflammatory response syndrome (SIRS), shortness of breath.

A continuous observation of the 100 hall New Admission Observation quarantine unit was made on 10/23/20 between 07:50 AM and ended at 08:10 AM revealed NA #4 was observed wearing a face mask and eye wear when she left Resident #9 after setting up her tray and entered Resident #10's room. Resident #10's room displayed signage that indicated Modified Droplet Contact Precautions. NA #4 sat the tray up and exited the room to obtain 2 cups of beverage without performing hand hygiene and returned to Resident #10's room with the cups. NA #4 was not observed to perform hand hygiene prior to exiting Resident #10's room.

1 c. Resident #12 was admitted to the New Admission Observation COVID-19 quarantine hall on 07/09/20 with diagnoses that included metabolic encephalopathy, asthma, and dementia.

A continuous observation of the 100 hall New Admission Observation quarantine unit was made on 10/23/20 between 07:50 AM and ended at 08:10 AM revealed NA #4 was observed to wear a face mask and eye wear while delivering breakfast meal trays. NA #4 was observed to enter Resident #12's and sat the tray on the overbed table. Resident #12 asked NA #4 for an item which she turned to the bedside table to retrieve and handed it to Resident #12 before returning to the breakfast tray to set up the food

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16	F 880		

items. NA #4 then exited the room without performing hand hygiene and approached the community beverage cart, poured a cup of coffee and then returned to Resident #12's room. NA # 4 then exited the room without performing hand hygiene.

An interview on 10/23/20 at 11:12AM with NA #4 revealed she had worn a facemask and eye wear when she delivered breakfast trays on the 100 hall New Admission Observation COVID-19 quarantine unit but did not don a gown or gloves because she had been taught gloves or a gown were not needed during meal service delivery. NA #4 stated she did not think about the need to perform hand hygiene after setting up Resident #9 and before proceeding to set up Resident #10's tray that morning. NA #4 also revealed she should have performed hand hygiene after interacting with Resident #12 and the community beverage containers should be sanitized if touched after contact with a resident on the quarantine unit. NA #4 indicated she had been taught gowns and gloves were not necessary on the 100 hall New Admission Observation COVID-19 quarantine unit unless providing incontinence care or coming in contact with the resident's nose or mouth.

An interview with the Infection Control Nurse/ ADON (IC) on 10/23/20 at 11:47 AM revealed the 100 hall was the New Admission Observation COVID-19 quarantine unit and all residents are on transmission-based precautions of Modified Droplet Contact Precautions. The IC nurse indicated a mask and eye wear were always to be worn when caring for residents on the unit. The IC nurse stated gloves and gowns were not needed unless performing incontinence care for

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17	F 880		

the residents on this unit. The IC nurse acknowledge signage posted on the doors of each resident room on the 100 hall illustrated the use of gloves and hand hygiene were needed; however, stated she did not believe NA #4 needed gloves to deliver meal trays to residents in rooms of transmission-based precautions. The IC Nurse stated NA #4 should have performed hand hygiene between every resident interaction on the New Admission Observation COVID-19 quarantine unit.

An additional interview on 11/19/20 at 9:52 AM with the IC Nurse revealed she was the facility's infection preventionist and was certified in infection control through the NC SPICE program in March 2020. The IC Nurse indicated she was responsible for the up-to-date IC policies and providing staff trainings in the updates in infection control practices. The IC Nurse explained she was following CMS and SPICE guidance. The interview also revealed the IC acknowledged she did not review or verify any additional guidance provided by the CDC website on PPE usage and appropriate isolation precautions.

An interview on 10/23/20 at 3:20 PM with the Director of Nursing (DON) and Administrator revealed the 100 and 500 halls were designated for all new admissions and COVID-19 residents who were on transmission-based precautions. They both acknowledged signage on the doors of each room indicated precautions which included needed PPE to be a mask, eyewear, and gloves at all times as well as a gown for incontinence care and hand hygiene was to be performed. The DON stated gloves, or a gown were not required to deliver meal trays to residents on the 100 unit who were under transmission-based precautions

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18	F 880		

because the staff were not performing incontinence care.

An interview on 10/26/20 at 10:26 AM with the local Health Department (HD) Nurse revealed all new admissions were to be placed on transmission-based precautions for 14 days following admission that must include the use of full PPE. The local HD Nurse indicated full PPE included a gown, gloves, eyewear, and gloves were always to be worn when interacting with a new admission for the 14-day quarantine period. The local HD Nurse also indicated thorough hand hygiene was to be performed after interactions with residents on transmission-based precautions. The local HD nurse indicated NA #4 potentially spread infection by not wearing gloves and performing hand hygiene while delivering meal trays to residents on the quarantine unit.

2. Resident #15 was admitted to the New Admission Observation COVID-19 quarantine hall on 08/08/20 with diagnoses that included hemiplegia affecting the left non-dominant side following cerebral infarction.

An observation on 10/23/20 at 10:45 AM revealed Nurse #7 enter Resident #15's room with a cup of pills and a box containing nasal spray. Nurse #7 was wearing a face mask and eyewear. Nurse #7 was not observed to be wearing a gown when she entered Resident #15's room. Nurse #7 sat both items on Resident #15's bedside table and exited the room and returned to the medication cart parked outside the door without performing hand hygiene. Resident #15's door displayed signage that indicated Modified Droplet Contact Precautions which included PPE needs to be a mask, eyewear, gloves, and gown when providing

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19	F 880		

incontinence care and that hand hygiene should be performed. Nurse #7 opened the medication cart and retrieved an insulin pen then returned to Resident #15's room and closed the door. Nurse #7 then opened Resident #15's door holding the insulin pen and the box of nasal spray with her ungloved hands. Nurse #7 was observed to unscrew the injection tip with her bare hands then discard the injection tip into the sharps box and place the syringe in the cart along with the box of nasal spray which was in contact with other resident's items in the cart then close the cart drawer. Nurse #7 was not observed to perform hand hygiene before beginning to push the medication cart in the hallway to complete the remainder of her mediation delivery.

An interview on 10/23/20 at 11:10 AM revealed Nurse #7 was a new nurse to the facility and worked the New Admission Observation COVID-19 quarantine unit. Nurse #7 stated she did not think about hand hygiene when delivering the medications to a Resident #15 who was on transmission-based precautions of Modified Droplet Contact Precautions although acknowledged Resident #15 had signage displayed on her door that indicated precautions that illustrated hand hygiene was to be performed and the use of gloves were required when entering Resident #15's room. Nurse #7 indicated she had not been taught there was any potential for cross-contamination of germs when a resident had touched a medication package and the medication being placed back in the cart along-side other medications in the hall medication delivery cart. Nurse #7 further revealed Resident #15 self-administers her own mediations and she did not think to apply gloves to discard the syringe after administration.

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20	F 880		

An interview with the Infection Control Nurse/ ADON (IC) on 10/23/20 at 11:47 AM revealed the 100 hall was the New Admission Observation COVID-19 quarantine unit and all residents are on transmission-based precautions of Modified Droplet Contact Precautions. The IC nurse indicated a mask and eye wear were always to be worn when caring for residents on the unit. The IC nurse stated gloves and gowns were not needed unless performing incontinence care for the residents on this unit. The IC nurse acknowledge signage posted on the doors of each resident room on the 100 hall illustrated the use of gloves and hand hygiene were needed; however, stated she did not believe gloves were needed to deliver medications to residents in rooms on transmission-based precautions.

An additional interview on 11/19/20 at 9:52 AM with the IC Nurse revealed she was the facility's infection preventionist and was certified in infection control through the NC SPICE program in March 2020. The IC Nurse stated Nurse #7 would not have needed to wear gloves when touching the soiled medication cup, box containing nasal spray, or the insulin pen when she exited the room of Resident #15. Nurse #7 would only use a mask and eyewear and performed hand hygiene while she administered medications to Resident #15.

An interview on 10/23/20 at 12:02 PM with the Director of Nursing (DON) the 100 hall was the New Admission Observation COVID-19 quarantine hall and all doors included signage that indicated residents were on Modified Droplet Contact Precautions. The DON stated she did not believe it was necessary to wear gloves to

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21	F 880		

administer medications of residents on transmission based precautions but explained that the nurse should not have had the syringe in her bare hand and Nurse #7 should have performed hand hygiene after she exited the room and before opening the medication cart to retrieve the insulin pen. The DON indicated Nurse #7 should have performed hand hygiene again after administering the medications. The DON did not feel it to be cross contamination for medications to be touching one another in the medication cart of residents on transmission-based precautions who had self-administered medications.

An interview on 10/23/20 at 3:20 PM with the DON and Administrator revealed the 100 hall were designated for all new admissions and COVID-19 residents who were on transmission-based precautions. They both acknowledged signage on the doors of each room indicated Modified Droplet Contact Precautions which included needed PPE to be a mask, eyewear, and gloves at all times as well as a gown for incontinence care and hand hygiene was to be performed. The DON stated gloves were not required for any interactions with residents on transmission-based precautions except performing incontinence care.

An additional interview on 11/19/20 at 10:03 AM with the DON revealed the IC Preventionist role in the facility was assigned to the Assistant Director of Nursing (ADON) who had been trained in infection control through the NC SPICE program this year and was responsible for the most up-to-date guidelines and guidance in best practices.

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22	F 880		

An interview on 10/26/20 at 10:26 AM with the local Health Department (HD) Nurse revealed all new admissions were to be placed on transmission-based precautions for 14 days following admission that must include the use of full PPE. The local HD Nurse indicated full PPE included a gown, gloves, eyewear, and gloves were always to be worn when interacting with a new admission for the 14-day quarantine period. The local HD Nurse also indicated thorough hand hygiene was to be performed after interactions with residents on transmission-based precautions. The local HD Nurse indicated Nurse #7 potentially spread infection by not wearing full PPE while administering medication and performing hand hygiene after administering medications to residents on the quarantine unit.

3. Resident #11 was admitted to the New Admission Observation COVID-19 quarantine hall on 10/9/20 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), liver transplant status, left femur fracture, and cognitive communication deficit.

An observation on 10/23/20 at 10:47 AM revealed Therapy Staff #1 and Therapy Staff #2 were in the hallway on the 100 Hall New Admission Observation COVID-19 quarantine hall with Resident #11. Therapy Staff #1 and Therapy Staff #2 were observed to wear a face mask and eye wear when interacting with Resident #11. Resident #11's door displayed signage that indicated Modified Droplet Contact Precautions that included illustration for the need of hand hygiene and gloves to be worn when contact with Resident #11 and a gown during incontinence care. Therapy Staff #2 was assisting Resident #11 to perform sit to stand exercises with

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23	F 880		

Resident #11 using the handrails attached to the wall. Therapy Staff #1 was typing on his computer that was located on a rolling desk in the hallway and approached Resident #11 and placed both hands on Resident #11's shoulders, leaned his head around to Resident #11's left side and spoke to Resident #11 whose face was 6-8 inches away. Therapy Staff #1 was not observed to perform hand hygiene before returning to his laptop and begin typing. Therapy Staff #2 pushed Resident #11 back into her room and exited into the hallway. Therapy Staff #1 and Therapy Staff #2 were wearing a face mask and eyewear but neither Therapy Staff #1 nor Therapy Staff #2 were observed to perform hand hygiene following interaction with the resident.

An interview on 10/23/20 at 11:02 with Therapy Staff #1 and Therapy Staff #2 revealed they acknowledged they had both touched Resident #11 who was on Modified Droplet Contact Precautions and had not followed it by performing hand hygiene. Therapy Staff #1 stated he typically was good to clean his laptop frequently but had not during the observation.

An interview on 10/23/20 at 11:47 AM with the Assistant Director of Nursing/ IC Nurse revealed the 100 hall was the New Admission Observation COVID-19 quarantine unit and all residents are on transmission-based precautions of Modified Droplet Contact Precautions. The IC Nurse indicated a mask and eye wear were always to be worn when caring for residents on the unit. The IC Nurse acknowledged signage posted on the doors of each resident room illustrated the use of gloves and hand hygiene were needed; however, the IC stated she did not believe gloves were needed to provide a therapy treatment in the

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24	F 880		

hallway to a resident on transmission-based precautions.

An additional interview on 11/19/20 at 9:52 AM with the IC Nurse revealed she was the facility's infection preventionist and was certified in infection control through the NC SPICE program in March 2020. The IC Nurse indicated she was responsible for the up-to-date IC policies and providing staff trainings in the updates in infection control practices. The IC Nurse explained she was following CMS and SPICE guidance.

An interview on 10/23/20 at 12:02 AM with the DON revealed the 100 hall was the New Admission Observation COVID-19 quarantine unit and all residents on that unit were on transmission-based precautions of Modified Droplet Contact Precautions which illustrated hand hygiene was required and the use of gloves were required for contact with the resident.

An additional interview on 11/19/20 at 10:03 AM with the DON revealed the IC Preventionist role in the facility was assigned to the Assistant Director of Nursing (ADON) who had been trained in infection control through the NC SPICE program this year and was responsible for the most up-to-date guidelines and guidance in best practices.

An interview on 10/26/20 at 10:26 AM with the local Health Department (HD) Nurse revealed all new admissions were to be placed on transmission-based precautions for 14 days following admission that must include the use of full PPE. The local HD Nurse indicated full PPE included a gown, gloves, eyewear, and gloves were always to be worn when interacting with a

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 11/19/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25	F 880		

new admission for the 14-day quarantine period. The local HD Nurse also indicated thorough hand hygiene was to be performed after interactions with residents on transmission-based precautions. The local HD Nurse indicated both Therapy Staff #1 and Therapy Staff #2 potentially spread infection by not wearing full PPE during care and performing hand hygiene after providing care for residents on the quarantine unit.

4. Resident #17 was admitted to the New Admission Observation COVID-19 quarantine hall on 10/22/20.
An observation on 10/23/20 beginning at 10:56 AM and ended at 11:00 AM revealed NA #4 entered Resident # 17's room to answer a call light that was on. NA #4 was observed to be wearing a face mask and eye wear. When NA #4 entered the room, she turned off the call light and asked Resident #17 what he needed. Resident # 17 told NA #4 he wanted some fresh ice in his water pitcher. NA #4 picked up the water pitcher and exited the room carrying the pitcher. NA #4 carried the pitcher down the 100 hall to the community nourishment room located on the end of the hall across from the nurses' station. NA #4 opened the door to the nourishment room with her bare hand and entered the room with Resident # 17's water pitcher. NA #4 then approached the ice machine, opened the lid with her hand, retrieved a scoop of ice, and put the fresh ice in the Resident #17's water pitcher. NA #4 then placed the scoop back in its container, closed the ice maker lid, and left the nourishment room with Resident # 17's water pitcher of fresh ice. NA #4 then returned to Resident # 17's room with the water pitcher and entered the room. NA #4 was not observed to perform hand hygiene before exiting Resident #17's room.

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F 880	Continued From page 26	F 880		

An interview on 10/23/20 at 11:12 AM with NA #4 revealed she worked the 100 hall New Admission Observation COVID-19 quarantine unit and had answered the call light for Resident #17 whom had requested fresh ice in his pitcher. NA #4 acknowledged Resident #17 was on Modified Droplet Contact Precautions and she had taken the water pitcher from a resident room whom was on isolation and filled it with ice in the nourishment room at the end of the hall instead of obtaining ice and bringing it to the room. NA #4 agreed that she potentially cross-contaminated surfaces when she removed the water pitcher from an isolation room and had touched multiple surfaces without performing hand hygiene which was a potential to spread infection.

An interview on 10/23/20 at 11:47 PM with the ADON/IC Nurse revealed 100 hall was a designated New Admission Observation COVID-19 quarantine unit and all residents on this hall were on precautions of Modified Droplet Contact Precaution. The IC Nurse indicated a mask and eye wear were required at all times when caring for residents on this unit. The IC nurse stated gloves and a gown were not needed unless performing incontinence care for the resident on the unit. The IC nurse acknowledged the signage posted on the doors of each room on the 100 hall illustrated the use of gloves and hand hygiene were needed; however, she stated she did not believe gloves were needed to provide fresh ice to the resident. The IC nurse indicated NA #4 should not have removed the soiled pitcher from Resident #17's room and taken it to the nourishment room to refill it. The IC Nurse explained NA #4 should have obtained a new water pitcher of ice and taken it to Resident #17's

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F 880	Continued From page 27	F 880		

room. The IC Nurse said NA #4 should have performed hand hygiene after she exited Resident #17's room.

An interview on 10/23/20 at 12:02 PM with the DON revealed Resident #17 resided on the 100 hall New Admission Observation COVID-19 quarantine unit and was on Modified Droplet Contact Precautions. The DON indicated she did not believe gloves or a gown were needed when obtaining fresh ice for Resident #17; however, did say that NA #4 should have taken a fresh pitcher of ice to Resident #17's room instead of removing the contaminated water pitcher from the room and into the community nourishment room at the end of the hall.

An interview on 10/26/20 at 10:26 AM with the local Health Department (HD) Nurse revealed all new admissions were to be placed on transmission-based precautions for 14 days following admission that must include the use of full PPE. The local HD Nurse indicated full PPE included a gown, gloves, eyewear, and gloves were always to be worn when interacting with a new admission for the 14-day quarantine period. The local HD Nurse also indicated thorough hand hygiene was to be performed after interactions with residents on transmission-based precautions. The local HD Nurse indicated NA #4 potentially spread infection by not wearing full PPE when in a resident room that displayed transmission-based precautions and touching surfaces with contaminated hands when NA #4 did not perform hand hygiene after providing fresh ice to a resident on the quarantine unit.