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 05/10/2019

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 survey was conducted from 05/06/19 to 05/10/19. The facility was found to be in compliance with the requirement of CFR 483.73, Emergency Prepardness Event ID #Y1NY11.	E 000		
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation. Event ID #Y1NY11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code behaviors on an annual Minimum Data Set assessment for 1 of 1 resident who exhibited behaviors and was reviewed for level II PASARR (Resident #30). Findings Included: Resident #30 was admitted to the facility on 11/13/19 with diagnoses that included, major depressive disorder and anxiety disorder. A review of Resident #30's annual Minimum Data Set (MDS) Assessment dated 03/15/19 revealed Resident #30 had moderately impaired cognition with episodes of hallucinations but no other behavioral symptoms. A review of Resident #30's care plan last reviewed on 03/15/19 revealed a care plan area	F 641	F 000 Disclaimer Cause: F641-483.20(g) Accuracy of Assessments Preparation and or execution of this plan does not constitute admission or agreement by the Provider of Truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. On March 11th, 2019 Nurse #4 documented in the nurses note that Resident #30 was demonstrating a behavior by yelling at her roommate. On March 11th, 2019 the Social Worker completed the behavior section on the Minimum Data Set and she did not code	5/13/19

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

Electronically Signed | 05/31/2019

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F 641	Continued From page 1 for having had a history of seeing and hearing people who were not there. Interventions included to administer medications as ordered while monitoring for effectiveness and to not argue with Resident #30 when she talked about seeing or hearing someone but reassure her she was safe. A review of Resident #30's progress notes revealed a note documented by Nurse #4 dated 03/11/19 at 10:58 PM which read in part: "episodes of confusion increased with periods of yelling at roommate, of false accusations about men molesting roommate, will continue to monitor, up in w/c at this time, call light within reach at this time". During an interview with MDS Nurse #1 on 05/10/19 at 11:20 AM, she revealed she did not complete the behavior section of Resident #30's MDS Assessment dated 3/15/19. She reported it was the responsibility of the Social Worker to accurately complete that section. During an interview with the Social Worker on 05/10/19 at 12:43 PM she revealed she was responsible for completing the behavior section of Resident #30's MDS Assessment dated 03/15/19. She reported to complete that section she reviewed physician progress notes and nurse's notes. When asked if she had reviewed the progress note dated 03/11/19, she reported she had but stated since the note did not indicate a specific date or time, she could not have determined if it was "a general statement or behavior" from the day the note was written. She reported since she could not determine what day or time the note indicated, she would not have coded the behavior on the Minimum Data Set	F 641	the behavior that was listed in the nursing note. On March 15th, 2019 the Minimum Data Set was completed but it did not indicate any behaviors for the resident, causing the Minimum Data Set to be inaccurate. On May 11th, 2019 the Administrator, Social Worker and MDS Coordinators ensured that each Minimum Data Set for every resident accurately portrayed any behaviors demonstrated by the resident by auditing all nursing notes and progress notes. The Social Worker and two MDS Coordinators were in-serviced on recognizing an actual behavior verses a “general statement” while reviewing nursing and progress notes during the lookback period when completing a Minimum Data Set on March 11th, 2019 by the Administrator. To ensure Quality Assurance, the Administrator, Social Worker and MDS Coordinators will review the nursing notes and progress notes daily (Monday thru Friday) to ensure any behavior documented is accurately coded on the Minimum Data Set. The weekend nursing notes will be reviewed each Monday by the Administrator, Social Worker and MDS Coordinators. This daily audit will occur for a minimum of twelve weeks. Findings from this audit will be presented in the Quality Assurance meeting for a minimum of four consecutive months.	

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F 641	Continued From page 2 Assessment dated 03/15/19. During an interview with the Administrator on 05/10/19 at 1:41 PM, she stated based on Nurse #4's progress note dated 03/11/19 at 10:58 PM, she would assume it was a behavior and indicated it should have been coded on Resident #30's Minimum Data Set Assessment dated 03/15/19. An interview with Nurse #4 on 05/11/19 at 4:37 PM revealed she did not write general statements in her notes. She stated she wrote the note dated 03/11/19 at 10:58 PM because she observed the behavior of Resident #30 yelling at her roommate.	F 641	All corrective action will be completed by May 13th, 2019.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		5/14/19

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F 656	Continued From page 3 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to implement fall care plan interventions for 1 of 6 residents investigated for supervision to prevent accidents (Resident #20). The findings included: 1. Resident #20 initially admitted to the facility on 12/04/17. Resident #20's diagnoses at the time included: Alzheimer's Disease, Parkinson's Disease, cerebrovascular accident, anxiety, and major depressive disorder. Review of a care plan dated 10/08/18 read in part, Resident #20 has a history of falling related	F 656	F656-483.21(b)(1) Develop/Implement Comprehensive Care Plan CFR(s) On May 6th thru May 8th, 2019 Resident # 20 did not have the metal pieces of the anti-rollbacks on her wheelchair. Anti-rollbacks were placed on her wheelchair as a fall intervention and were listed on Resident #20's care plan. With the metal pieces of the anti-rollback not being on the wheelchair; the facility failed to implement the fall care plan interventions. On May 8th thru May 10th, 2019 the Administrator, MDS Coordinators and	

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F 656	Continued From page 4 to decreased functional mobility. Resident #20 was impulsive and often did not understand her functional limitations. The goal of the care plan read, Resident #20 would be free from injury until next review. The interventions included: anti-roll back device to wheelchair. Review of the quarterly Minimum Data Set (MDS) dated 02/25/19 revealed that Resident #20 was severely cognitively impaired for daily decision making. The MDS further revealed that Resident #20 required extensive assistance with activities of daily living and had 1 fall with no injury since the previous assessment and 1 fall with no major injury since the previous assessment. Resident #20 was recently readmitted to the facility on 04/12/19. Resident #20's diagnoses at time included: fall, closed head injury, acute intracranial hemorrhage and epilepsy. An observation of Resident #20 was made on 05/06/19 at 10:45 AM. Resident #20 was sitting in her wheelchair in front of the sink in her room washing her hands. She was nonverbal but would smile and wave her hand. There were no anti-roll back device to the back of her wheelchair. The metal pieces of the anti-roll back device that would keep the wheelchair from rolling backwards were missing. An observation of Resident #20 was made on 05/06/19 at 3:30 PM. Resident #20 was up in her wheelchair at bedside. She was nonverbal but smiled and waved her hand. There were no anti-roll back device to the back of her wheelchair. The metal pieces of the anti-roll back device that would keep the wheelchair from rolling backwards were missing.	F 656	Nursing Administration team ensured that all fall interventions were in place for every resident that had fall interventions listed on their care plan. This was completed by auditing all fall care plan interventions and matching them to what was currently in place for each resident. All C.N.A. care guides were audited for accuracy as well. All Administration members, C.N.A's and nurses were in-serviced on the importance of making sure that fall interventions were in place by the Administrator, Director of Nursing and Assistant Director of Nursing on May 11th thru May 13th, 2019. Employee signatures will reflect their understanding. To ensure Quality Assurance, Administration staff or designee will make daily room rounds to ensure all care planned fall interventions are in place. The Maintenance Director will also make daily rounds (Monday thru Friday) to ensure that all fall interventions are in place and functioning properly for eight weeks, and then weekly for eight weeks. This check was added to the Daily Room Round check off sheet that is completed by the Department Heads or designee each morning. These audits will be conducted for a minimum of sixteen weeks. Findings from these audits will be presented in the Quality Assurance meeting for a minimum for four consecutive meetings. All corrective action will be completed by	

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F 656	Continued From page 5 An observation of Resident #20 was made on 05/07/19 at 10:45 AM. Resident #20 was propelling self around the unit in her wheelchair. She was nonverbal but smiled and waved her hand. There were no anti-roll back device to the back of her wheelchair. The metal pieces of the anti-roll back device that would keep the wheelchair from rolling backwards were missing. An observation of Resident #20 was made on 05/08/19 at 9:15 AM. Resident #20 was propelling herself to the beauty shop to have her hair done. She was nonverbal but smiled and waved her hand. There were no anti-roll back device to the back of her wheelchair. The metal pieces of the anti-roll back device that would keep the wheelchair from rolling backwards were missing. An observation and interview were conducted with the Maintenance Director (MD) on 05/08/19 at 1:58 PM. The MD was observed to be adjusting Resident #20's wheelchair brakes. He stated that he was walking around the facility and noticed that Resident #20's wheelchair was missing the metal anti-roll back device. The MD stated that he also found other residents that were missing theirs as well, so he was replacing all of them. The MD stated he was not sure if the metal pieces were getting broken off or what the issue with the missing metal pieces was but stated he was just replacing them all. An interview was conducted with Nursing Assistant (NA) #1 on 05/08/19 at 2:21 PM. NA #1 confirmed that she routinely cared for Resident #20 and was familiar with her care needs. She stated that Resident #20 liked to be independent and do things for herself. She added that they	F 656	May 14th, 2019.	

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F 656	Continued From page 6	F 656		

assisted her as needed and as Resident #20 would allow. NA #1 indicated that Resident #20 fell a lot and they tried to explain to her that she can not get up by herself. She added that the staff educate Resident #20 to lock her wheelchair brakes and ring the call light for assistance but most of the time she would not do those things. NA #1 referred to her care guide (guide of each resident needs) and stated that Resident #20 had fall mats to both sides of her bed and had non-skid strips to the floor in her room. NA #1 could not recall if Resident #20 had anti-roll backs to her wheelchair and referred to her care guide but did not see it listed there.

An interview was conducted with Medication Aide (MA) #1 on 05/08/19 at 2:30 PM. MA #1 confirmed that she routinely cared for and was familiar with Resident #20. MA #1 stated that when the facility implemented new fall interventions the Administration team would let the MAs on the hall know and then they would report them to the NAs on the hall. MA #1 could not recall if Resident #20 had anti-roll back to her wheelchair or not but stated at one time she did.

An interview was conducted with the Director of Nursing (DON) on 05/09/19 at 11:29 AM. The DON stated that it was the facility practice to implement a new fall intervention with each fall. Once the intervention had been implemented it was placed on the care plan and then weekly during the facility's focus meetings they discussed the implemented interventions and discussed if they were effective or not.

A follow up interview was conducted with the DON on 05/10/19 at 11:34 AM. The DON stated that long term fall care plan interventions were

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F 656	Continued From page 7 verified on administration rounds. The staff member would take a care guide and compare what was on the guide to what was in place. The DON stated that if the anti-roll backs were missing she would expect the staff member to report it immediately and all ordered fall care plan interventions should be in place as ordered. An interview was conducted with the Administrator on 05/10/19 at 12:24 PM. The Administrator stated that she expected all care plan interventions to be in place as ordered.	F 656		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to cover facial hair	F 812	F812-483.60(i)(1)(2) Food procurement, Store, Prepare/Serve □ Sanitary	5/11/19

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F 812	Continued From page 8 while serving the lunch meal for 1 of 1 meal observations. The practice of not covering hair had the potential to affect the food being served to the residents. The findings included: Review of a facility policy titled "Food Preparation and Service" with no date noted read in part, "Dietary staff shall wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does note contact food." A brief tour of the kitchen was made on 05/06/19 at 11:15 AM with the Dietary Manager (DM). Cook #1 was observed preparing food for the upcoming lunch service. Cook #1 was observed open/closing and taking items out of the oven and placing them on the steam table. Cook #1 was observed to have a ball cap on his head but his beard, mustache, and goatee that were neatly trimmed were uncovered. A continuous observation of the lunch meal service was conducted on 05/06/19 from 11:58 AM to 12:54 PM. Cook #1 was observed plating meals for the residents in the facility. Cook #1 was observed to have a ball cap on his head but his beard, mustache, and goatee that were neatly trimmed were uncovered. An observation of Cook #1 was made on 05/07/19 at 11:47 AM. Cook #1 was in the food preparation area and had a ball cap on his head but his beard, mustache, and goatee that were neatly trimmed were uncovered. An interview with Cook #1 was conducted on 05/07/19 at 1:46 PM. Cook #1 stated he had	F 812	On May 6th, 2019 Cook #1 was preparing food for the upcoming lunch service without covering his facial hair. The facilities policy and procedure titled Food Preparation and Service states, Dietary staff shall wear hair restraints (hair nets, hat, beard restraints) so hair does not contact the food. Cook #1 not having his facial covered had the potential to affect food being served to the residents. On May 8th, 2019 the Administrator and Dietary Manager ensured that all dietary employees had all their hair and any facial hair covered properly to reflect the facilities policy and procedure titled Food Preparation and Service. All dietary employees were in-serviced on the facilities policy and procedure titled Food Preparation and Service by the Dietary Manager on May 8th thru May 10th, 2019. Employee signatures reflect their understanding of this in-service. To ensure Quality Assurance, daily kitchen rounds will be completed to ensure that all hair and facial hair is properly covered by the Dietary Manager or designee for six weeks, and then weekly for six weeks. The Food and Preparation and Service policy will be reviewed with all new hires by the Administrator or designee before they are permitted to work. The Food Preparation and Service policy will also be reviewed quarterly with all other current employees. Employee signatures will reflect their understanding and will be	

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F 812	Continued From page 9 been at the facility for 10 years in the dietary department. He stated that he always wore his base ball cap on his head and further stated that when his facial hair was grown out he wore a bread guard. Cook #1 confirmed that he did not have a beard guard on covering his facial hair on 05/06/19 during the meal preparation/service and on 05/07/19 because he had recently trimmed his facial hair and did not think he needed one. An interview was conducted with the DM on 05/08/19 at 3:10 PM. The DM stated Cook #1 has always worn a beard guard and she had been instructed that if he only had a little bit of facial hair than he did not have to wear the beard guard. She added that she has never had to speak to Cook #1 about the beard guard because he generally always had it in place. The DM stated that she expected Cook #1 to have a beard guard in place anytime he was in the food preparation area. An interview was conducted with the Registered Dietician (RD) on 05/08/19 at 4:43 PM. The RD stated that she visited the facility often and never had to remind Cook #1 about the beard guard because he was so complaint. The RD stated that anytime Cook #1 was in the food preparation area his facial hair should be covered. An interview was conducted with the Administrator on 05/10/19 at 12:24 PM. The Administrator stated that Cook #1 always wore a beard guard and this was an isolated event. She continued to say that she had never had an issue with Cook #1 or his wearing a beard guard. The Administrator stated, "he always wears a cap and a beard guard."	F 812	presented in the Quality Assurance meeting for a minimum of six consecutive months. All corrective action will be completed by May 10th, 2019.	