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 01/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 01/16/23 through 01/18/23. The facility was found in compliance with requirement CFR 483.73, Emergency Preparedness. Event ID# 5D0811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/16/24 through 01/18/24. Event ID#5D0811. The following intake was investigated: NC00209237. One (1) of 1 compaint allegation did not result in a deficiency.	F 000		

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

Electronically Signed | 02/02/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345246	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/18/2024

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment within 14 days of the discharge date for 1 of 1 resident reviewed for resident assessment (Resident #1). The findings included: Resident #1 was admitted to the facility on 09/06/23.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Continued From Page 1

Review of Resident #1's medical record revealed he was discharged home on 10/10/23 with family and home health services.

Review of Resident #1's medical record revealed the last completed MDS assessment was an admission assessment dated 09/13/23. There was no discharge assessment completed or transmitted.

During an interview on 01/18/24 at 10:54 AM with MDS Coordinator #1 and MDS Coordinator #2, they explained the discharge assessment for Resident #1 had been missed and had been brought to their attention today after an audit had been completed by the corporate nurse. MDS Coordinator #2 stated it was just overlooked and would be completed and transmitted today but would be late and not within the regulatory guidelines. She further stated it should have been completed and transmitted within 14 days of the resident's discharge.

During an interview on 01/18/24 at 3:16 PM, the Administrator stated she thought the error had occurred because the resident was listed as benevolent (no payment to the facility) with managed care insurance but said the discharge MDS should have been completed and transmitted within the regulatory guidelines.

F 867

QAPI/QAA Improvement Activities
CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)

§483.75(c) Program feedback, data systems and monitoring.
A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse

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HICKORY FALLS HEALTH AND REHABILITATION	**100 SUNSET STREET GRANITE FALLS, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 867	Continued From Page 2

events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 867	Continued From Page 3

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation that occurred on 09/20/22. This was for one deficiency cited during the 09/20/22 survey in the area encoding/transmitting resident assessments and subsequently cited on the current recertification and complaint investigation survey of 01/18/24. The continued failure of the facility during these two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program.

The findings included:

This tag is cross referred to:

F640: Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment within 14 days of the discharge date for 1 of 1 resident (Resident #1) reviewed for resident assessment.

During the recertification and complaint investigation survey conducted on 09/20/22, the facility failed to complete and transmit a discharge MDS assessment for 1 of 1 resident reviewed for discharge.

During an interview on 01/18/24 at 3:16 PM with the Administrator, she reported her quality assurance team met monthly and included the Medical Director, Director of Nursing, Assistant Director of Nursing, Treatment Nurse, Dietary Manager, Pharmacist (quarterly), Registered Dietician (quarterly), Social Worker, Activities Director, and a rotating staff member. The Administrator stated she felt like they had resolved the issue of MDS assessments by having two full time MDS Coordinators and said she thought they were confused by the resident's benevolent (no payment to the facility) with managed care status.