PRINTED: 12/19/2025
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018039	A. BUILDING: _____ B. WING _____	R 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY VILLAGE	427 3RD AVENUE SE HICKORY, NC 28602

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D 000	Initial Comments The Adult Care Licensure Section and the Catawba County Department of Social Services conducted an annual and follow-up survey on 12/03/25-12/04/25.	D 000	Responses to the cited deficiencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared soley as a matter of compliance with state laws.	
D 263	10A NCAC 13F .0802 (f) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (f) The care plan shall be revised as needed based on the results of a significant change assessment completed in accordance with Rule .0801 of this Section. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 5 sampled residents (#2) had a care plan assessment completed within 10 days of a significant change when the resident was admitted to hospice care. The findings are: Review of Resident #2's current FL2 dated 01/21/25 revealed: -Diagnoses included vascular dementia, hypothyroidism, heart disease, chronic kidney disease and emphysema. -Resident #2 was semi-ambulatory. Review of Resident #2's Resident Register revealed an admission date of 03/26/25 Review of Resident #2's hospice record completed 07/14/25 revealed:	D 263	10A NCAC 13F .0802(f) Executive Director and/or Resident Care Coordinator will complete an audit of resident care plans to ensure care plans have been updated timely and in accordance with rule area 0802(f). Executive Director and Resident Care Coordinator will be inserviced by facility nurse on the importance of timely care plan revisions to include a significant change assessment when a resident is admitted to hospice or has any other significant change. Executive Director and/or designee will review no less than 2 care plans per week for 60 days to ensure ocmpliance with timely revisions of care plans.	02/01/2026

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Amanda Randles TITLE ED (X6) DATE 1/12/26

Reviewed and Acknowledged by SSD on 01/16/26 Sharon Dunton RN

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D 263	Continued From page 1 -There was an order for hospice to begin 07/11/25. -A hospice RN was to evaluate Resident #2 and develop a nursing plan of care and skilled nursing visits to observe and assess physical symptoms and evaluate efficacy of plan of care. -The hospice nurse was to assess medication response and instruct staff on schedule, actions, purpose, side effects, compliance and need to report side effects to hospice staff for Resident #2. -The hospice nurse was to monitor Resident #2's pain level and report ineffective pain control to the Primary Care Provider (PCP). -The hospice nurse was to provide infection control education to Resident #2's care givers. Review of Resident #2's PCP progress notes dated 10/21/25 revealed: -Resident #2 was currently under hospice care, focusing on symptom management and quality of life. -The plan was to continue symptom control and coordinate with the hospice team to ensure comprehensive palliative care. Review of Resident #2's PCP progress notes dated 11/18/25 revealed she remained on hospice care. Review of Resident #2's care plan dated 04/14/25 revealed: -There was no significant change noted on the care plan after Resident #2 was admitted to hospice care on 07/11/25. -There was no documentation indicating the care being provided by hospice services related to Resident #2's symptom management and coordination with hospice for palliative care services being provided.	D 263		

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D 263	Continued From page 2 Interview with the Resident Care Coordinator (RCC) on 12/04/25 at 11:05am revealed: -The RCC was responsible for care plans and updating care plans. -Resident #2 had no new symptoms. -Resident #2 had a weight loss but weights did not usually trigger a significant change. Interview with the Regional Support Nurse on 12/04/25 at 11:20am revealed: -She expected a significant change to be documented on the care plan. -The care plan was to be updated as needed and the RCC was responsible for the update. -The staff were doing nothing different with Resident #2's care when she came under hospice care. Interview with the Administrator on 12/04/25 at 11:20am revealed: -The PCP felt Resident #2 was declining and the daughter was notified of the change. -The RCC was responsible for the care plan to be changed when a significant change happened. -She was not aware the care plan was not changed when Resident #2 went on hospice care. -She was not sure the RCC read the hospice notes to remind them of the plan of care.	D 263	10A NCAC 13F .1004(i) Facility nurse will inservice medication aides to include Executive Director and Resident Care Coordinator on the importance of observing residents taking medications during administration process.	02/01/2026
D 366	10A NCAC 13F .1004 (I) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication	D 366	Executive Director and/or Resident Care Coordinator will observe no less than 5 medicationadministrations per week for 60 days to ensure compliance with rule area 1004(i).	

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D 366	Continued From page 3 immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed 1 of 1 sampled resident (#1) take his medications related to a resident observed lying on his bed with eyes closed and a medication cup containing medications in pudding sitting on his bedside table. The findings are: Review of Resident #1's current FL2 dated 09/02/25 revealed: -Diagnoses included Alzheimer's disease, major depressive disorder, anxiety, vitamin D deficiency and seasonal allergies. -There was an order for cetirizine (a medication to treat allergies) 10mg, one tablet daily. -There was an order for cimetidine (a medication to decrease stomach acid) 400mg, one tablet daily. -There was an order for divalproex delayed release (DR) sprinkles (a medication to treat mental health disorders) 125mg, two capsules twice daily. -There was an order for escitalopram (a medication to treat depression) 10mg, one tablet daily. -There was an order for vitamin D3 (a vitamin supplement to treat low vitamin D3 levels) 25mcg, one tablet daily.	D 366		

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D 366	Continued From page 4 -There was an order for lorazepam (a medication to treat anxiety) 0.5mg, one tablet each morning. Observation on 12/03/25 at 9:24am revealed: -Resident #1's door was closed. -Resident #1 was lying on his bed with his eyes closed. -There was a medication cup of pudding or applesauce-like substance containing medications and a spoon on his bedside table. -It could not be determined the exact number or description of the medications in the substance. -The MA was down the hall in the medication room. -The MA was asked to walk with the surveyor back to the Resident #1's room and she confirmed the medication cup contained Resident #1's morning medications. -The MA woke Resident #1 and asked him to take his medication. -The resident sat up, used the spoon, scooped the medications into his mouth, swallowed and dropped the empty cup in his trash can. Interview with a medication aide (MA) on 12/03/25 9:24am revealed: -Resident #1 was one of the younger and more alert residents in the facility. -The medication cup on Resident #1's bedside table were his morning medications in pudding. -She administered Resident #1's 8:00am medications to him that morning (12/03/25). -When she took Resident #1 his 8:00am medications to his room that morning (12/03/25) he was standing and moving about his room. -She handed Resident #1 his medication cup and thought he took his medication and dropped the cup in his trash can as he typically did. -Resident #1 must have set his medications on his bedside table and laid back down on his bed.	D 366		

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D 366	Continued From page 5 -She was responsible to watch Resident #1 swallow his medications but thought he was taking them. Review of Resident #1's December 2025 electronic Medication Administration Record (eMAR) from 12/01/25 to 12/03/25 revealed: -There was an entry for cetirizine 10mg one tablet daily scheduled for administration at 8:00am and documented as administered at 8:00am on 12/03/25. -There was an entry for cimetidine 400mg one tablet daily scheduled for administration at 8:00am and documented as administered at 8:00am on 12/03/25. -There was an entry for divalproex DR sprinkle 125mg two capsules twice daily scheduled for administration at 8:00am and 8:00pm and documented as administered at 8:00am on 12/03/25. -There was an entry for escitalopram 10mg one tablet daily scheduled for administration at 8:00am and documented as administered at 8:00am on 12/03/25. -There was an entry for vitamin D3 25mcg one tablet daily scheduled for administration at 8:00am and documented as administered at 8:00am on 12/03/25. -There was an entry for lorazepam 0.5mg one tablet daily scheduled for administration at 8:00am and documented as administered at 8:00am on 12/03/25. Review of medications available for administration for Resident #1 revealed: -Resident #1's "Morning" multi-dose pack of medications contained cetirizine 10mg one tablet, cimetidine 400mg one tablet, divalproex DR 125mg two capsules, escitalopram 10mg one tablet and vitamin D3 25mcg one tablet.	D 366		

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D 366	Continued From page 6 -Resident #1 had a bubble pack of lorazepam 0.5mg with 9 tablets remaining, with instructions to administer one tablet every morning. Interview with Resident #1 on 12/04/25 at 10:16am revealed: -The MAs always handed his medication to him. -Not all MAs watched him take his medication. -The MA yesterday morning (12/03/25) handed his medication to him and he set the medication cup on his bedside table before lying back down on his bed. Telephone interview with Resident #1's Nurse Practitioner (NP) on 12/04/25 at 10:14am revealed: -She expected the MAs to watch all residents swallow their medications. -The facility was a Special Care Unit (SCU) and a resident could have wandered into Resident #1's room and ingested the medication he left on the bedside table. Interview with Special Care Coordinator (SCC) on 12/04/25 at 10:45am revealed: -All MAs were trained when hired and annually to watch all residents swallow their medication. -Resident #1 liked to take his medication on his own. -Resident #1 sometimes needed reminded to take his medication immediately when it was handed to him and not walk away from the MA with it in his hand. -She never observed any medications left at a residents' bedside. Interview with Administrator on 12/04/25 at 10:59am revealed: -The MAs were responsible for observing residents' medication administration, including	D 366		

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D 366	Continued From page 7 ensuring the resident had swallowed the medications. -Resident #1 was high functioning but medications at his bedside were a safety concern for the other residents who could wander into the room and ingest the medication.	D 366		