STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345310	A. BUILDING _____ B. WING _____	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CROSSING	100 HEDRICK DRIVE THOMASVILLE, NC 27360

(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 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the assessment in the area of hospice care on 3 (Residents # 27, #62 & #14) of 3 sampled residents receiving hospice. The findings included:	F 278	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Piedmont Crossing of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is	7/15/15

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

Electronically Signed | 07/29/2015

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F 278	Continued From page 1 1. Resident #27 was admitted to the facility on 1/4/12. On 6/10/14, the attending physician had ordered hospice for the resident. The quarterly Minimum Data Set (MDS) assessment dated 5/22/15 indicated that Resident #27 was not receiving hospice care. On 7/8/15 at 5:20 PM, MDS Nurse #1 was interviewed. She stated that she started as an MDS Nurse in September, 2014 with no previous MDS experience/training. She acknowledged that she did not code hospice care on the MDS assessment for Resident #27 and that she will complete a modification assessment to correct it. 2. Resident # 62 was admitted to the facility on 4/9/14. On 3/24/15, the attending physician had ordered hospice for the resident. The quarterly Minimum Data Set (MDS) assessment dated 6/15/15 indicated that Resident #62 was not receiving hospice care. On 7/8/15 at 5:20 PM, MDS Nurse #1 was interviewed. She stated that she started as an MDS Nurse in September, 2014 with no previous MDS experience/training. She acknowledged that she did not code hospice care on the MDS assessment for Resident #62 and that she will complete a modification assessment to correct it. 3. Resident # 14 was admitted to the facility on 2/9/15. On 2/9/15, the attending physician had ordered hospice for the resident. The quarterly Minimum Data Set (MDS) assessment dated 5/13/15 indicated that Resident #14 was not receiving hospice care. On 7/8/15 at 5:20 PM, MDS Nurse #1 was interviewed. She stated that she started as an MDS Nurse in September, 2014 with no previous MDS experience/training. She acknowledged	F 278	submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare and Medicaid programs if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey date, and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance. Prefix Tag: 278 It is the intent of this facility to accurately code the assessment in the area of Hospice care on all applicable residents. Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. The residents (27, 62 and 14) had their MDS assessments modified to correct the error in coding. The MDS assessments were re-submitted and accepted on 7/8/2015. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient	

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F 278	Continued From page 2 that she did not code hospice care on the MDS assessment for Resident #14 and that she will complete a modification assessment to correct it.	F 278	practice: On 7/9/2015, all Hospice residents in the facility were identified and their MDS was checked for accuracy by the DON and MDS Coordinator. Any discrepancies in Section O were modified and those MDS assessments were again transmitted and accepted. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Health Information Coordinator will audit MDS coding for all patients on Hospice monthly and report findings to DON for a minimum of 6 months. Findings will be recorded on a Hospice Reconciliation Form. All audit forms are reviewed and signed by DON monthly. MDS Coordinators were educated by DON in the following areas: How to locate the Hospice contract in the Electronic Medical Record. A notification will be sent out by the Business Office Manager via email when a resident becomes Hospice Any changes such as a resident becoming Hospice will be discussed in Morning Meeting. MDS nurses attended conference conducted by Mary Maas in June 2015. MDS Coordinator will be attending conference in August 2015 to become	

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F 278	Continued From page 3	F 278	certified. Other MDS nurse will obtain certification via on-line classes. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to administer the prescribed dose of Morphine Sulfate extended release to 1 of 1 resident (Resident #140) resulting in an overdose on 3 separate occasions. Findings included: Resident #140 was admitted to the facility on 10/17/14 with a diagnosis of chronic pain for which she had been prescribed Morphine Sulfate extended release (MS ER) 45 milligrams (mg) by	F 333	Prefix Tag: 333 It is the intent of this facility to ensure that residents are free of any significant medication errors. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. Resident #140 had the medication error	7/15/15

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F 333	Continued From page 4 mouth twice daily. The resident's cognition was assessed on 1/14/15 to be severely impaired and she was noted to be using scheduled and 'as needed' pain medications. Resident #140's care plan dated 5/13/15 instructed staff to administer medications as ordered for chronic pain. Physician's orders stated: 11/6/14 "Take MS ER 15 mg by mouth twice daily." The prescribed dose was increased on 1/15/15 to "Take MS ER 30 mg by mouth twice daily." And finally, again increased on 5/7/15 to "Take MS ER 45 mg by mouth twice daily." The Medication Administration Record for the order dated 5/7/15 stated: "MS ER Take one 30 mg tablet with one 15 mg tablet (for a total of 45 mg) by mouth twice daily." Medications received from pharmacy included: 11/6/14 - MS ER blister pack 15 mg tablets 1/15/15 - MS ER blister packs of 30 mg tablets 5/7/15 - MS ER blister packs of 15 mg tablets with instructions to "Take 3 (THREE) tablets by mouth twice daily ***NOTE DOSE***" (for a total of 45 mg each dose)." Pharmacy especially noted "***NOTE DOSE*** (for a total of 45 mg each dose)" in the directions portion of the blister pack label. A photo copy of the blister pack indicated that someone handwrote a note at the top in bold marker "Give 3 tabs = 45 mg" and put asterisks besides the pharmacy written directions. The narcotic inventory sheet of MS ER 15 mg had "Take 3 tablets" underlined also.	F 333	identified and corrected on May 12, 2015. On May 12, 2015, Shift Supervisor for the unit verified by comparing the labeling on the Narcotic punch card and the active order in the Electronic MAR. Labelling was then placed on the narcotic punch card denoting to check dosing instructions. On May 21st, the order in the Electronic MAR was changed to match the way the pharmacy filled the narcotic by the Shift Supervisor. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: On July 8th thru July 9th DON/ADON along with Medication Aides compared the narcotic labelling on the Narcotic Punch Cards against the order in the Electronic Medical Record. All current residents in the facility that were on narcotics at the time were reviewed. If the orders did not match, any discrepancies were immediately corrected by comparing the order in the Electronic MAR to the order written in the chart. If the medication punch card had instructions that did not match the way the order was inputted into the Electronic MAR, then the order in the Electronic MAR was amended to match the punch card. If the punch card label was incorrect and did not match the physician¿s order, then pharmacy was notified and a new punch	

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F 333	Continued From page 5 The photo copy of the blister pack showed that when the blister pack cards of 15 mg tablets were received from pharmacy on 5/7/15, there was a quantity of 24 tablets of 30 mg MS ER remaining in the blister pack card refilled on 4/17/15. There was no indication that the blister pack card of MS ER 15 mg with instructions to Take 1 tablet with the 30 mg MS ER was available in the narcotic drawer from which the medication aide could formulate a dose amount of 45 mg. On 5/8/15 at 9:00 AM, 5/11/15 at 9:00 AM, and 5/12/15 at 9:00 AM the narcotic inventory sheets indicated that Medication Aide #1 administered MS ER 30 mg with MS ER 3 tablets of 15 mg (45 mg) for total of 75 mg per dose to Resident #140. Administrative Staff #3 was interviewed on 7/9/15 at 8:00 AM. She stated "We discovered this error when the following medication aide notified us after she noticed that the error occurred 3 times. When we did our investigation, we discovered that what most likely happened is that Medication Aide #1 saw on the Medication Administration Record (MAR) Give 30 mg tablet and Give 15 mg tablet (for a total of 45 mg); but the pharmacy label said Give 3 of the 15 mg tablets so she gave one 30 mg tablet and three 15 mg tablets for a total of 75 mg MS ER." Administrative Staff #3 indicated that the facility policy is to have staff pull the blister pack cards of old medications out of the medication cart to return to pharmacy upon receiving new blister pack cards. She stated "I don't know why it was not pulled and there is really no way of tracking who should have pulled it. Pharmacy, in fact, noted in bold, capital letters, and asterisks on the directions "Note new dose". The resident was not	F 333	cards with proper labelling were sent. Incorrectly labelled cards are removed immediately from the medication cart. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. A Root Cause Analysis was performed and completed on July 13th thru July 14th with the facility pharmacy consultant and the following procedure was instituted: All Medication Aides were educated to check the pharmacy instruction label on all received medications against the Electronic MAR Any discrepancy must be reported to the charge nurse and corrected prior to the medication being placed on the cart An audit form will be placed on the medication cart by the Shift Supervisor and discrepancies will be logged by the Medication Aide along with the nurse. ADON/SDC will pick up forms daily to ensure that corrections were made accurately in the Electronic MAR and that any corrections match the written physician¿s order. We will obtain a complete list of all narcotics delivered to the facility daily from our pharmacy.¿ The list will be obtained by the DON, ADON, Shift Supervisors and Weekend Coordinator. ¿¿All narcotics will be checked daily for 4 weeks by Shift Supervisors; then narcotics will be checked on Tue, Thur and Sat times 8 weeks by the Shift Supervisors; then	

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F 333	Continued From page 6 affected by the dose of the error at all." The Administrative Staff #3 further indicated that the process of filling narcotic medications is that, after the physician writes an order, a nurse supervisor is supposed to enter the order onto the facility's electronic MAR and then fax the original prescription to the pharmacy to have filled. She indicated that in this situation, the nurse supervisor entered the order into the MAR as Take 30 mg and 15 mg but pharmacy filled it as 15 mg (take 3 tablets). She further indicated that, at the time of the investigation and to date, the facility did not have a process of reconciling narcotic medications that were received from pharmacy to what was entered into the MAR by a facility nurse to ensure that what was read on the MAR was indeed what was written on the pharmacy label. She also stated that, at the time of the investigation and to date, the facility did not have a process of ensuring that all old doses of medications were removed from the medication carts upon receiving new medications. She added that "This error was considered an "isolated case" and not reviewed for further suggestions at the Quality Assurance committee meetings." Administrative Staff #2 was interviewed on 7/9/15 at 8:10 AM. She stated "I get a copy of the medications that are to be returned to pharmacy. Our process of returning medications to pharmacy is for the weekend staff to go through all of the medication cart to pull out expired medications and medications that are no longer in use. The 30 mg MS ER blister pack was not returned to pharmacy because we did not want to waste the medication. We figured that the medication aides would continue to give 1 table of 30 mg MS ER and 1 tablet of 15 mg MS ER, but	F 333	narcotics will be checked on Friday by the Shift Supervisors for 8 weeks.¿ Finally, narcotics will be checked monthly by pharmacy consultant. The audit form will be signed off daily (if corrections occurred) and the ADON will report findings weekly to the DON. DON will report any necessary findings to Omnicare Pharmacy on a weekly basis. 4) Facility¿s plan to monitor its performance so solutions are sustained and integrated into the facility¿s quality assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON/Pharmacy Consultant will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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F 333	Continued From page 7 instead Medication Aide #1 got confused and gave 1 tablet of 30 mg and 3 tablets of 15 mg MS ER. (Resident #140) was not affected by the error at all, we monitored her. We in-service staff about removing old medications from the medication carts but we did not in-service the staff about this error specifically; we felt this was an isolated case." She further described that because of the 'isolation' of this error, the facility did not give consideration to improving their process of reconciling narcotic medications nor has the facility set up a process by which they ensured old medications were removed from the medication cart on time. Medication Aide #1 was interviewed on 7/9/15 1:00 PM. She stated "I swear that the MAR said to give 30 mg and 3 tablets of 15 mg. I kept looking at the order and thinking that it was high but I know what I saw. I also noticed on the narcotic inventory sheets that the other shifts were only giving 1 tablet of the 15 mg MS ER. At that time, I thought they had made a medication error of not giving enough morphine."	F 333		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356		7/15/15

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F 356	Continued From page 8 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to accurately post nurse staffing information. The findings included: The Nurse Staffing Report and the Daily Assignment Sheets for 7/1/15 through 7/9/15 were reviewed. On each day the staff members assigned to the Supervisor role were accounted for on the Nurse Staffing Report. On 7/9/15 at 9 AM Administrative Staff #2 was interviewed. She stated that Nurse Supervisors were not included in the Nurse Staffing Report when she completed the form because they were not considered direct care staff, or on the schedule as direct care staff, although they did provide direct care at times. Administrative Staff	F 356	Prefix Tag: 356 It is the intent of this facility to accurately post nurse staffing information Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. Nursing staff posting was corrected at time of deficiency by the Staffing Coordinator to reflect licensed and unlicensed nursing staff directly responsible for resident care. 2) Corrective action to be accomplished for those residents having potential to be affected by the alleged deficient practice.	

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F 356	Continued From page 9 #2 also said that the Scheduler typically completed the staff posting documentation. On 7/9/15 at 9:47 AM the Scheduler was interviewed. She stated that she did include the Nurse Supervisors on the Nurse Staffing Report. She said she counted each Nurse Supervisor who was assigned on any shift, for all hours of their assignment each day. The Scheduler stated that she was aware the Nurse Supervisors only spent a portion of their time providing direct care but that she had always counted 100% of their time on the Nurse Staffing Report as that was what she had been told to do in the past.	F 356	DON provided instructions to staffing coordinator, ADON and Weekend Supervisor on proper completion of posting for next scheduled posting and how to determine staff hours to be excluded when nursing staff are not directly responsible for resident care per shift. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Staffing Coordinator educated at time of deficiency that any licensed nurse in a supervisory role when he/she is not directly responsible for patient care per shift cannot have hours counted as licensed nurse hours on the Nursing Staff Posting. Form used for Nursing Staffing Post was modified to include only licensed nurse hours when staff is directly responsible for patient care per shift. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the ADON weekly with oversight by the Administrator through the QAPI process. The ADON will put her initials at the bottom of the staffing sheet indicating that she has reviewed the posting for 4 weeks and monthly thereafter. The ADON will report on the measures implemented to	

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F 356	Continued From page 10	F 356	the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to date and label facility prepared food in 1 of 1 walk in refrigerator in the kitchen, failed to date the supplement (mighty shakes) when removed from the freezer in 2 (400 and 500 hall) of 4 nourishment refrigerators and failed to maintain the chocolate pudding at 40 degrees Fahrenheit (F) or below on 2 (200 and 300) of 2 halls observed during the tray line. Findings included: The facility's policy on " Use by/discard dates guidelines " dated 11/14/14 was reviewed. The policy indicated " when dating products, please put the date the item was opened or prepared	F 371	Prefix Tag: F371 It is the intent of this facility to Procure food from sources approved or considered satisfactory by Federal, State or local authorities Store, prepare, distribute and serve food under sanitary conditions Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. The pudding was thrown away and replaced with pre-packaged pudding. All of the Health Shakes were dated for July 21, 2015.	7/29/15

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F 371	Continued From page 11 and the date it must be used by. Day one starts the date it was opened/prepared. Leftover food production that has been properly cooled, facility prepared ready to eat items, canned goods that have been opened and most all other food products are good for 3 days. Health shakes are good for 14 days once removed from the freezer. " 1. On 7/6/15 at 11:50 AM, tour of the kitchen was conducted. In the walk in refrigerator, there were 2 big aluminum pans with fried chicken and roast beef observed. The pans were not dated nor labeled. At 12:05 PM, administrative staff #1 was interviewed. She identified the food as fried chicken and roast beef and stated that they should been dated and labeled. 2a. On 7/8/15 at 9:50 AM, the nourishment refrigerators were observed. On 400 hall nourishment refrigerator, there were 8 cartoons of mighty shakes observed that were not dated. The shakes were already thawed. At 4:40 PM, dietary aide #2 was interviewed. She stated that she didn't know that she had to date the shakes when pulled from the freezer. She added that she thought that the shakes were good until the expiration date. On 7/9/15 at 9:45 AM, administrative staff #1 indicated that the shakes should have been dated once pulled from the freezer and they were good for 14 days. 2b. On 7/8/15 at 9:50 AM, the nourishment refrigerators were observed. On 500 hall nourishment refrigerator, there were 15 cartoons of mighty shakes observed that were not dated. The shakes were already thawed. On 7/9/15 at	F 371	All refrigerators were checked to ensure that food was properly labelled 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: Formulated new procedure for pureed desserts to be made a day in advance to ensure that they at the correct temperature. Education provided by the Director of Dining for all dietary staff on new procedure, proper food temps for hot and cold foods. Education began on 7/13/15 and was completed on 7/29/15. Education provided by the Director of Dining for all dietary staff regarding proper procedure for labelling and dating all food items. Education began on 7/13/15. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Director of Dining, Chef Manager, RD and Supervisor to check all refrigerators daily to ensure compliance with labelling and dating policy. A form was prepared to document this measure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345310	A. BUILDING _____ B. WING _____	C 07/09/2015

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F 371	Continued From page 12 9:20 AM, dietary aide #3 was interviewed. She stated that she should have dated the shakes when she pulled them from the freezer but she forgot. At 9:45 AM, administrative staff #1 indicated that the shakes should have been dated once pulled from the freezer and they were good for 14 days. 3a. On 7/8/15 at 12:15 PM, the tray line on 200 hall was observed. The facility's thermometer was calibrated before checking the food temperature by administrative staff #1. The chocolate pudding was already prepared in a cup ready to be served. The temperature of the pudding was 59 degrees F. Administrative staff #1 indicated that the chocolate pudding was prepared in the kitchen using the chocolate pudding powder and mixed with milk and water and the temperature should be maintained at 40 degrees F and below. She instructed the dietary aide to put the chocolate pudding back in the refrigerator. 3b. On 7/8/15 at 12:30 PM, the tray line on 300 hall was observed. The food temperatures were checked after the facility's thermometer was calibrated by administrative staff #1. The temperature of the chocolate pudding was 73 degrees F. The pudding was in an aluminum pan. At 12:50 PM, dietary aide #1 was interviewed. She stated that she was aware that the chocolate pudding was made from chocolate pudding powder and mixed with milk and water and should have been kept in a cooler and maintained below 40 degrees F. She added that she was so busy that she did not have time to cool it off. The chocolate pudding was observed to have been served to a resident.	F 371	Cooks, overseen by Chef Manager, will check the temperature of food prior to leaving main kitchen. All dietary personnel with oversight by Director of Dining will ensure temperatures at point of service. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the Director of Dining daily with oversight by the Administrator through the QAPI process. Findings will be reported to the Administrator weekly for 4 weeks and monthly thereafter. The Director of Dining will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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