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 04/21/2016

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 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		5/11/16

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, and staff interviews, the facility failed to provide the resident with a right foot rest on her broda chair to prevent the resident's foot from slipping during transportation in the broda chair and getting under the chair which resulted in the fracture of the femur to 1 of 3 residents reviewed for accidents. (Resident #1).

Past noncompliance: no plan of correction required.

Findings included:

Resident #1 was admitted to the facility on 7/23/15 with diagnoses which included: chronic congestive heart failure, muscle weakness, difficulty in walking, and a history of a right hip fracture.

Review of the quarterly Minimum Data Set (MDS) dated 1/13/16 indicated Resident #1 was cognitively severely impaired; required extensive assistance of two staff with transfers; required total assistance of one staff with locomotion on and off of the unit; and, had no limitation with the range of motion of her extremities.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/11/2016

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 DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 1	F 323		

Review of the Occupational Therapy (OT) Evaluation dated 3/29/16 indicated Resident #1 was referred for therapy due to a new onset of decrease in range of motion, decreased postural alignment and, reduced static and dynamic balance placing the resident at risk for muscle atrophy, contracture(s), decreased participation with functional tasks, decreased skin integrity, and pneumonia. The resident's family requested that the resident have a broda chair (specialized wheelchair) for greater support to her back and to assess for decreased leaning over side of chair-right.

The OT Note dated 3/30/16 revealed Resident #1 was up in a broda chair with good positioning; no lateral leaning or forward sliding. The left foot pedal was in place; however, the right foot pedal was bent and unable to latch. The staff were educated on the use of the broda chair for daily use. The objective was to have the right foot pedal adjusted for appropriate fit to allow proper foot positioning while the resident was up in the broda chair.

Review of the Occurrence Report dated 3/31/16 revealed that on 3/30/16, one of the foot pedals of Resident #1's wheelchair was removed by Therapy because it was not latching properly to her chair. Therapy put in a work order with the Maintenance Department to repair the chair. Before Maintenance could repair the chair, the resident was being rolled down the hallway with both feet on the one good foot rest. The resident's right foot fell off of the foot rest and went under the wheelchair as it was being rolled. The resident complained of knee pain. The nursing assistant stated when she realized what happened she stopped propelling the chair and

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 04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 2	F 323		

the resident started saying "my knee hurts really bad." "My knee is broke." The nurse assessed the knee and it did not appear swollen at that time. Pain medication was administered and the nurse practitioner was notified and he assessed the resident. An x-ray was ordered which indicated an acute distal femoral fracture. Orders were received and the resident was sent to the hospital via the emergency medical services for further evaluation.

The review of the summary from the Hospital's Emergency Department dated 3/30/16, revealed Resident #1 was diagnosed with a closed fracture of the distal end of the right femur. The resident was given 25mcg (microgram) injection of fentanyl (pain medication), home care instructions and a follow-up appointment with Orthopedics for 3/31/16.

The Orthopedic's Note dated 3/31/16 indicated Resident #1 had a non-operative fracture that required pain control in a dementia patient and should be closely observed and modified by the facility's staff. The Note revealed the family of Resident #1 chose conservative management, with strict non-weight bearing and the resident was to stay in the right leg immobilizer.

In a report of the investigation of the incident by the RN/NHA (registered nurse/nursing home administrator) dated 4/1/16, a Root Cause Analysis was completed revealing that Resident #1 should have had both foot rests on the chair despite her ability to hold both legs on the same foot pedal.

The Occupational Therapy Note dated 4/4/16 indicated Resident #1's use of the broda chair

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 04/21/2016

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

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F 323	Continued From page 3 was discontinued due to the change in her status due to her fractured femur. Facility staff were educated on positioning the resident in a geri-chair using a mechanical lift for transfers requiring the assistance of two staff with one staff supporting the resident's right leg. On 4/20/16 at 1:30pm, Resident #1 was observed in a geri-chair being propelled by a nursing assistant in the hallway. The resident was alert, sitting upright with feet elevated. The resident's legs were covered with a blanket and the resident displayed no signs of pain. During an interview on 4/20/16 at 2:19pm, SN#1 (Staff Nurse #1) revealed that she had worked with Resident#1 for three months and that the resident was alert, verbal but very confused. SN#1 stated that the resident always required two leg rests due to the resident was unable to hold her legs up. She also revealed that the resident never attempted to propel herself in the wheelchair. SN#1 stated that on 3/30/16, prior to the incident, NA#1 (Nursing Assistant #1) informed her the leg rest on the resident's wheelchair was not functioning, and she (NA#1) had also informed the Therapy Department about it (Therapy responsible for assigning wheelchairs and leg rests), but after asking two to three times, Therapy had not returned it or given her a new one for the resident. SN#1 revealed that she was informed by Therapy staff that the leg rest was given to the Maintenance department for repair. SN#1 revealed that between 12:00pm-1:00pm, NA#1 requested that she (SN#1) assess the resident's leg due to the resident's leg fell off of the leg rest of her wheelchair. NA#1 informed her (SN#1) that while she was propelling the resident up the hall to the dining room in the wheelchair,	F 323		

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 04/21/2016

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F 323	Continued From page 4 the resident's right leg fell off of the leg rest and went under the wheelchair. NA#1 informed SN#1 that she had placed both of the resident's legs on one leg rest in a crossed position. SN#1 stated she observed NA#1 standing behind the resident's wheelchair and another nursing assistant holding the resident's right leg in an extended position. The resident refused to allow SN#1 to touch her knee. SN#1 instructed the two nursing assistants to transport the resident back to her room (NA#1 pushing the wheelchair while the other nursing assistant holding the resident's extended right leg). SN#1 stated that she notified her immediate supervisor and the NP (Nurse Practitioner) who was on-site that day. The NP attempted range of motion on the resident's right leg, the resident was crying and yelling. The NP noted that the leg wasn't swollen and was unsure if the pain the resident was experiencing was part of her chronic pain (old hip fracture) or if there was a new injury. When NP asked SN#1 opinion, SN#1 revealed that she informed him that the resident's crying and yelling was not part of her usual signs of chronic pain. The NP made decision at that time to have an x-ray completed of resident's leg on-site. Until the x-ray was done, the resident's pain was managed with tramadol (pain medication). SN#1 revealed the results of the x-ray as a fracture of the distal end of the femur. The Physician was notified and an order was received to have the resident transported to the hospital via emergency medical services for evaluation. SN#1 stated that the hospital stabilized the resident's leg with an immobilizer and the resident returned to the facility with a follow-up appointment with the Orthopedics Specialist. SN#1 revealed NA#1 should not have propelled the resident in a wheelchair with both feet on one leg rest. SN#1 also revealed that	F 323		

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 04/21/2016

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

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F 323	Continued From page 5	F 323		

NA#1 informed her that therapy staff instructed her to cross the resident's legs and put both feet on one leg rest. SN#1 stated that when she spoke with therapy staff, she was informed that they (therapy) told NA#1 to be careful.

During an interview on 4/20/16 at 3:47pm, NA#1 revealed she had worked with Resident #1 since her admission and that the resident was alert, verbal and able to answer most questions. NA#1 stated that the resident was able to lift her legs; but, resident always had two footrests on her wheelchair. NA#1 revealed the resident very rarely propelled herself in the wheelchair. The day of the accident was the resident's second day in the broda chair. NA#1 indicated that the Therapy department educated her on the proper use of the broda chair when the resident received it; and at that time the footrests worked fine, would latch without a problem. NA#1 stated that prior to the incident on 3/30/16, the resident was able to stand and pivot. NA#1 revealed that on 3/30/16 at 7:30am, she noticed that the right footrest on the resident's broda chair would not latch, so she removed it to avoid skin tears or bruising. NA#1 revealed that she then crossed the resident's right leg so that the resident's right foot rested on top of her left foot which rested on the left footrest and proceeded to propel the resident to the dining room for breakfast. On the way to the dining room, NA#1 informed one of the therapist about the broken right footrest. The resident was returned to her room after breakfast by another nursing assistant, without incident. NA#1 stated that when she arrived to resident's room to transfer her from the wheelchair to her recliner, she noticed that the broken footrest had been removed and assumed therapy had it. NA#1 indicated that at approximately 10:00am, she

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 04/21/2016

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

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F 323	Continued From page 6 transferred the resident from her recliner to the wheelchair and positioned the resident's legs the same as she did earlier. While propelling resident to the shower room, NA#1 asked a different therapy staff about the leg rest for the resident's chair; the therapist informed her that the leg rest was being worked on. NA#1 stated that during lunch time, while on her way to kitchen, she noticed the resident was still in her room in her broda chair (the resident should have been in the dining room for restorative dining). NA#1 revealed that she place the resident's right leg in the same position that she had done all morning (crossed onto left leg). As NA#1 propelled the resident in the broda chair across her room and through the doorway, the resident never yelled out. As they proceeded down hallway, NA#1 revealed that she felt a jolt and stopped immediately, bent down in front of the resident and saw that the resident's right leg was bent and her right foot was on the floor instead of the footrest; NA#1 asked resident what was wrong, what hurt, and she indicated that the resident complained of knee pain and that her "knee was broke". NA#1 indicated that the resident moved her right leg from beneath wheelchair area and was able to move her ankle. NA#1 revealed she placed the resident's right leg back into the crossed position on the left foot rest. NA#1 stated that the resident did not grimace, yell, or cry or verbalize pain. NA#1 indicated that as she propelled resident towards the dining room, she stopped and informed a staff nurse of the incident and that the resident complained of knee pain. The staff nurse did not observe any swelling and the resident was not crying. After leaving the resident in the dining room, NA#1 stated that she informed the Nurse Supervisor of incident. NA#1 revealed that she was informed by a restorative nursing assistant that the resident	F 323		

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 04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 7	F 323		

was returned to her room due to the resident was in dining room crying that her pain was getting worst.

During an interview on 4/21/16 at 12:23pm, the COTA (Occupational Therapist Assistant) revealed Resident#1 was evaluated by therapy for positioning due to her family's request due to trunk weakness and lateral leaning. She indicated that the resident was unable to propel herself in a wheelchair. A broda chair was obtained during evaluation. The COTA stated that the day after receiving the broda chair, she arrived at the resident's room for her usual treatment and was informed by NA#1 the footrest would not lock and that she (NA#1) gave it to the therapist for repair. The COTA revealed that she located the footrest on the occupational therapist's desk. She stated that she checked the footrest and realized it was bent; therefore would not latch. The COTA indicated that she then contacted the Maintenance Supervisor who said he would work on it after lunch. The COTA stated that the broda chair probably should not have been used, until the food rest could have been repaired. She revealed that it was not appropriate for the nursing assistant to place both of the resident's feet on the left footrest due to safety reasons. The COTA concluded that it would have been appropriate for therapy to provide an alternative means of transporting the resident, such as in a geri-chair, until the footrest was repaired. She also stated that had she been made aware that the resident was to eat lunch in the dining room and not in her room, then an alternative means of transportation would have been provided.

During an interview on 4/21/16 at 10:50am, the RN/NHA revealed that as the result of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PIEDMONT CROSSING	**100 HEDRICK DRIVE THOMASVILLE, NC 27360**

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F 323	Continued From page 8 investigation of the incident, the QAPI Committee, of which she was a member, conducted a Root Cause Analysis Summary on 3/31/16 and a plan of correction was initiated on the same day. The RN/NHA presented a plan of correction with a corrective date of 4/11/16, which consisted of: 1) On 3/31/16, Resident #1 was transported and seen by a local Orthopedist. An immobilizer was placed and the resident was determined not to be a candidate for surgery. Pain medication was prescribed. The resident's broda chair was removed from service until repaired and both foot pedals operational. The incident was reviewed by the IDT (Inter Disciplinary Team) to determine root cause and intervention on Kardex-Footrest needs to be in place when transported in a broda/wheelchair. Completion date of 3/31/16. On 4/1/16, Resident #1's Kardex was updated by the DON (Director of Nursing) and NS#1 (Nursing Supervisor) to reflect the resident must be transported in a broda/wheelchair with leg rests and foot pedals. DON requested that the therapist assess the resident for therapy needs and proper chair positioning. Completion date of 4/1/16. 2) On 3/31/16, the second shift nursing staff reviewed all residents in the facility to determine those residents needing leg rests and/or foot pedals on their broda and/or wheelchairs. It was determined that residents who self-propel themselves are safer without leg rests and/or foot pedals and these residents were identified. One resident was identified as needing foot pedals and were installed. One resident's personal chair lacked foot pedals and family was notified. This resident was provided a facility wheelchair until family can equip/repair her personal chair. Completion date of 3/31/16. On 4/1/16, the DON and SN#2 held in-services with all Health Care Staff with instructions: 1. All	F 323		

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 04/21/2016

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PIEDMONT CROSSING	**100 HEDRICK DRIVE THOMASVILLE, NC 27360**

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F 323	Continued From page 9 residents who are transported in wheelchairs and that do not use their legs to self-propel will have leg rests. 2. The nursing department along with therapy will ensure that all leg rests are appropriate and in good repair. 3. No resident requiring leg rests will be transported in a wheelchair without the leg rests. 4. The nursing department will audit residents during transport to ensure compliance daily. 5. Any resident requiring leg/foot rests will have this information placed in their Kardex. Facility Department Managers to monitor for compliance of use of footrest while transporting residents. Reporting to QAPI Committee using the Nursing Facility Observation Audit as directed by QAPI Committee. Facility QAPI will evaluate the effectiveness of intervention measures by a decrease noted in incidents related to non-use of footrest when providing transportation to our residents. Completion date of 4/4/16. 3) a. Facility-wide in-service 4/7/16. DON will present Safety in Motion to all staff. Completion date of 4/7/16. b. All department managers will have their staff in-serviced by 4/11/16, pertaining to Safety in Motion. Completion date of 4/11/16. c. All department managers will monitor staff compliance with the new initiative, Safety in Motion. The data (Nursing Facility Observation Audits) will be reported at the QAPI meeting. 4) These measures will be monitored by the DON with oversight by the Administrator through the Quality Assurance process. The DON will report on the measures implemented to the QAPI Committee which will monitor for effectiveness for minimum of twelve months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are	F 323		

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 04/21/2016

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

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F 323	Continued From page 10	F 323		

acted upon in a timely manner. Facility department managers will monitor for compliance use of footrests while transporting residents using the Nursing Facility Observation Audit.
5) The facility made the decision to formulate the QAPI (Quality Assurance and Performance Improvement) on 3/31/16.

Throughout the survey period (4/19/16 through 4/21/16), observations were made of facility staff propelling residents in wheelchairs and broda chairs with the residents' feet correctly positioned on both leg rests. On 4/19/16 at 2:36p, Resident #4 was observed in her room, sitting in a wheelchair with her feet on the left and right foot pedals. On 4/21/16 at 1:32pm, Resident #2 was observed in the dining room in a broda chair with her feet positioned on the right and left foot pedals. Resident #1's Care Plan and Kardex were updated to include the requirement of both leg rests attached to her broda/wheelchair. Review of facility records revealed in-services were conducted from 4/1/16 through 4/7/16 on ensuring leg rests were applied to and used for wheelchairs and broda chairs of residents who were unable to propel themselves. The Nursing Facility Observation Audits were completed daily beginning 3/31/16, ensuring all identified residents requiring leg rests on their wheelchairs and/or broda chairs were monitored by the Director of Nursing, the Assistant Director of Nursing, the Nursing Supervisor, and the Charge Nurse.