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 09/09/2022

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/6/22 through 9/9/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 6YGZ11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation were conducted 9/6/22 through 9/9/22. See Event # 6YGZ11. Two of the 5 complaint allegations were substantiated resulting in the deficiencies of F880 and F658. The following intakes were investigated: NC00189962 and NC00192249. 10/31/22 - The CMS form 2567 was amended to reflect changes as a result of the IDR dated 10/21/22	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		9/28/22

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

Electronically Signed | 09/28/2022

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F 623	Continued From page 1	F 623		

paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal

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F 623	Continued From page 2	F 623		

hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

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F 623	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record reviews, family and staff interviews, the facility failed to provide the resident and/or responsible party (RP) written notification of the reason for a hospital transfer for 2 of 3 residents reviewed for hospitalization (Residents # 32 and #14). The findings included: 1. Resident #32 was admitted to the facility on 4/25/22. A quarterly Minimum Data Set (MDS) assessment dated 7/27/22, indicated Resident #32 had moderately impaired cognition. Resident #32's medical record revealed she was transferred to the hospital on 8/23/22 for mental status changes. There was no documentation that a written notice of transfer was provided to the resident and/or responsible party (RP) for the reason of the transfer. Resident #32 returned to the facility on 8/26/22. The Administrator was interviewed on 9/7/22 at 3:35 PM and explained a written reason for hospital transfer was sent with the resident in the hospital discharge packet. The Administrator added there was no other written notification regarding the hospital transfer that was sent to the RP and/or resident, but they were always notified verbally. She stated she would expect the resident and/or RP to be notified in writing for the reason of the hospital transfer per the regulation. During a phone call on 9/8/22 at 3:15 PM, with Resident #32's RP, she indicated she had not	F 623	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 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: F623 It is the intent of this facility to provide the resident/resident representative notification of transfer/discharge 1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 9/21/2022, the Nursing Home	

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F 623	Continued From page 4 received anything in writing regarding the reason for hospital transfer on 8/23/22, although she was notified by phone. 2. Resident #14 was admitted 12/21/21. Review of Resident #14's medical record indicated a family member was listed as her responsible party (RP). Review of Resident #14's significant change Minimum Data Set dated 4/15/22 indicated she was cognitively intact. Resident #14's medical record revealed she was transferred to the hospital on 6/21/22 due to a fall. There was no documentation that a written notice of transfer was provided to the resident and/or RP for the reason of the transfer. Resident #14 returned to the facility on 6/24/22. The Administrator was interviewed on 9/7/22 at 3:35 PM and explained a written reason for hospital transfer was sent with the resident in the hospital discharge packet. The Administrator added there was no other written notification regarding the hospital transfer that was sent to the RP and/or resident, but they were always notified verbally. She stated she would expect the resident and/or RP to be notified in writing for the reason of the hospital transfer per the regulation. During a phone call on 9/8/22 at 1:50 PM with Resident #14's RP, she indicated she had not received anything in writing regarding the reason for hospital transfer on 6/21/22, although she was notified by phone.	F 623	Administrator delivered the Notice of Transfer/Discharge to resident #32's RP and explained the intent and content of the form. Resident #14 received the Notice upon transfer, and we will not give a notice to her Responsible Party at this time due to rapidly decline of resident and the emotional distress of her family. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice A resident change master is emailed to all Department Heads to notify them each time a resident is discharged for any reason. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Each morning during our Morning Meeting the Interdisciplinary Team discusses residents that have been discharged to the hospital. This meeting will serve as a reminder that the Social Worker or the Health Information Coordinator (in the Social Worker's absence) will need to mail a copy of the Notice of Transfer/Discharge to the resident's Responsible Party. A note will be placed into the resident's chart verifying that the Notice has been	

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F 623	Continued From page 5	F 623	mailed. 4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. These corrective measures will be monitored by the Health Information Coordinator with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Health Information Coordinator will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		9/28/22

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F 657	Continued From page 6 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to revise the care plan in the area of falls. This was for 1 (Resident #48) of 4 residents reviewed for falls. The findings included: Resident #48 was admitted on 5/3/22 with a diagnosis of Coronary Artery Disease. The quarterly Minimum Data Set (MDS) dated 7/21/22 indicated severe cognitive impairment and was coded for one fall without injury. Review of Resident #48's comprehensive care plan last revised on 8/10/22 included a care plan for a risk of falls initiated on 5/21/22. Review of Resident #48's medical record revealed she sustained an actual fall on 7/17/22	F 657	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 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	

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F 657	Continued From page 7 and another fall on 8/22/22. There were no injuries and interventions implemented were appropriate. On 9/9/22 at 12:00 PM, an interview was completed with MDS Nurse #1. She stated Resident #48's fall care plan should have been revised after the quarterly MDS dated 7/21/22 to include the fall she sustained on 7/17/22. She also stated the fall that occurred on 8/22/22 should have also been added to the fall care plan to reflect Resident #48's current falls with updated interventions. MDS Nurse #1 stated it was an oversight. On 9/9/22 at 12:45 PM, the Administrator stated Resident #48's fall care plan should be an accurate reflection of her current status along with the new interventions.	F 657	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: F657 It is the intent of this facility to revise the care plan in the area of falls. 1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 9/9/2022 the MDS Nurse added the falls intervention into the resident's care plan. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice On 9/12/2022 a report was generated from our Risk Watch program by the Nursing Home Administrator to include all residents that had experienced a fall in the quarter beginning July 1, 2022, to present date. The MDS nurses compared the interventions in the Incident Reports to the resident's care plans to validate that the interventions had been placed into the care plan.	

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F 657	Continued From page 8	F 657		

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

Each morning during our Morning Meeting the Interdisciplinary Team will discuss residents that have fallen.

Together, the team will determine appropriate interventions, and the intervention will be placed into the care plan at that time.

If more information must be gathered to identify the root cause of the fall, then the Director of Nursing will email the interventions to the appropriate MDS Nurse.

4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed.

These corrective measures will be monitored by the appropriate MDS Nurse with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The MDS Nurses will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the corrective

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F 657	Continued From page 9	F 657	measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 658 SS=B	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff interviews and record review, the facility failed to discontinue a wander/elopement alarm in the absence of wandering. This was for 2 (Resident #14 and Resident #68) of 2 residents reviewed for personal alarms. The findings included: 1. Resident #14 was admitted on 12/31/21. . Resident #14's significant change Minimum Data Set (MDS) dated 4/15/22 indicated she was cognitively intact, exhibited wandering behaviors for 1 to 3 days and not coded for wander/elopement alarm. A wander/elopement alarm was ordered for Resident #14 on 4/21/22. Review of Resident #14's nursing notes for April, May and June 2022 revealed occasions of wandering, gathering her things and verbalizing she was going to leave and go back to her	F 658	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 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	9/28/22

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apartment. There were nursing notes documenting her increased confusion and episodes of delusions thought to be related to her urinary tract infections. There was no documented evidence of an actual elopement.

Review of a nursing note dated 6/20/22 at 10:00 PM, Resident #14 had ambulated to the bathroom and slipped. She did not call for staff assistance prior to her fall. An x-ray revealed a left hip fracture and she was sent out to the hospital on 6/21/22 and readmitted to the facility 6/24/22.

Review of a Resident #14's readmission Physician order dated 6/24/22 read her wander/elopement alarm was reordered.

Review of an Elopement Risk Assessment dated 6/24/22 indicated Resident #14 was not an elopement risk.

Review of Resident #14's care plan initiated 6/24/22 did not include a risk area related to wandering behaviors with the use of a wander/elopement alarm.

Resident #14's significant change MDS dated 6/30/22 indicated she was cognitively intact, exhibited no wandering behaviors and was coded for wander/elopement alarm. The MDS was coded for no ambulation in her room or on the unit and coded for extensive staff assistance for locomotion on and off the unit.

Review of Resident #14's Treatment Administration Records for 7/12/22 to 9/8/22 indicated the nurse's checked the function of her wander/elopement alarm each shift.

other allegation or action. This plan of correction serves as the allegation of substantial compliance.

Prefix Tag: F658
It is the intent of this facility to properly assess elopement risk for all residents and to discontinue wander/elopement alarms in the absence wandering.

1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice

On 9/9/2022, the elopement deterrent device was removed from resident #14 by the Charge Nurse.

On 9/9/2022, an Elopement Risk Assessment was completed by the Nursing Home Administrator. The score indicated that the resident was not an elopement risk, and the elopement deterrent device was removed. The resident's Kardex and Care Plan were updated accordingly.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice

On 9/21/2022, an Elopement Risk Assessment was completed by the Director of Nursing for all residents (not including Memory Support) currently wearing an elopement deterrent device. Changes were made according to the resident's elopement risk score.

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F 658	Continued From page 11 An observation and interview was completed on 9/6/22 at 11:47 AM with Resident #14. She was asked pull up her right pant leg to allow visualization of her wander/elopement alarm. She stated the alarm had been in use for "a while" and stated that she was not able to ambulate anymore and accepted the facility as her home. She stated at one time she was ambulating throughout the facility with her friend. An interview was completed on 9/7/22 at 4:00 PM with Nurse #1. She stated prior to Resident #14's fall in June 2022, she was able to ambulate throughout the skilled halls. She stated Resident #14 never breeched the locked door leading to the assisted living hall and the front exit but the potential was there. That was the reason she was ordered a wander/elopement alarm back in April 2022. Nurse #1 further stated since Resident #14 was readmitted on 6/24/22 after her fall and resulting hip fracture, she was no longer ambulating and the alarms should probably come off. Review of Resident #14's electronic medical record included an order dated 9/7/22 discontinuing the wander/elopement alarm. An interview was completed on 9/8/22 at 11:07 AM with Nursing Assistant (NA) #5. She stated started working at the facility a few months ago and since she started, she had never observed Resident #14 wandering or stating she wanted to leave the facility. An interview was completed on 9/8/22 at 11:10 AM with NA #2. She stated she had worked at the facility for 7 years. NA #2 stated Resident #14	F 658	3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Residents that have an elopement deterrent device will be discussed quarterly with the Interdisciplinary Team to determine the appropriateness of continuing the device. The resident's care plan and Kardex will be updated at that time if appropriate 4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. These corrective measures will be monitored by the designated MDS Coordinators with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The MDS nurses will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that	

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used to have a male friend and they would walk about the facility before he died earlier this year. She stated since his death, Resident #14 was more confused and was having delusions. She stated the wander/elopement alarm was added for her safety. NA #1 stated since Resident #14 fell and broke her hip, she was no longer a risk for wandering or elopement.

A telephone interview was completed on 9/8/22 at 1:21 PM with Nurse #5. He stated Resident #14 was no longer a wander/elopement risk. He stated her alarm should have been discontinued once it was determined that she was not going to rehabilitate to ambulating again after her readmission in June 2022.

A telephone interview was completed on 9/8/22 with Nurse #7. She stated Resident #14 at one time was experiencing increased confusion after her friend died but since falling and breaking her hip, she appeared to have really gone downhill quickly and was no longer able to wander or exit seek. She stated she was unsure why Resident #14 still had the alarm.

A telephone interview was completed on 9/8/22 at 1:54 PM with Nurse #8. She stated Resident used to get up and wander about the facility but never had an unsupervised exit. She stated since her readmission in June 2022, she was no wandering and seldom got out of the bed. She stated she did not understand why she still had the alarm.

An interview was completed on 9/9/22 at 12:45 PM with the Administrator. She stated when Resident #14 was readmitted in June 2022, her wander/elopement alarm order was carried over

recommendations are acted upon in a timely manner.

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without considering the Elopement Risk Assessment completed on her readmission and she was unable to explain why the alarm was not discontinued at that time. She stated it should have not been reordered on her readmission.
2. Resident #68 was originally admitted to the facility on 10/20/21 with diagnoses that included dementia.

Resident #68's active physician orders included an order for a wander alarm dated 12/21/21.

A review of Resident #68's nursing progress notes from 12/1/21 to 5/30/22 revealed the following behaviors that staff described as wandering: stating she needed to go home, walking in the hallway, looking for her purse and/or family members in other rooms, and walking on a different hallway stating she was lost or looking for markers. There were no further behavioral symptoms after 2/3/22.

An Elopement Risk Assessment form dated 5/30/22 indicated the resident was at risk of getting to a dangerous place and had an elopement deterrent device was implemented.

A review of Resident #68's behavior logs from 5/31/22 through 8/24/22 did not show any behaviors logged by the Nurse Aides (NA). Per the legend on the behavior log, pacing, rummaging, and wandering were included for choices to select if present.

A quarterly Minimum Data Set (MDS) assessment dated 8/24/22 indicated Resident #68 was alert and oriented and displayed no behaviors, wandering or rejection of care. She required supervision and setup for walking in the

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room/corridor and locomotion on the unit. She required supervision and 1 staff member for locomotion off the unit. She was coded with a wander/elopement alarm used daily.

An Elopement Risk Assessment form dated 8/25/22 indicated the resident was not at risk for elopement but an elopement deterrent device remained implemented.

A review of Resident #68's behavior logs from 8/25/22 through 9/8/22 did not show any behaviors logged by the NAs.

The MDS Nurse #2 was interviewed on 9/8/22 at 3:45 PM and was the staff member that completed the Elopement Risk Assessment from 8/25/22. She reviewed and verified she marked all wandering and exit seeking behavior as "no" because Resident #68 was not exhibiting any of those behaviors but felt the wander alarm should remain on due to the potential for exit seeking and wandering due to her confusion at night and "not as many staff are here during the evening and night times". When asked if the wander alarm had been discussed for the potential of removal since there had been no behaviors of wandering or exit seeking since February 2022, the MDS Nurse #2 stated "no, because what if she needed it again".

An interview occurred with Resident #68 on 9/8/22 at 11:30 AM. She was sitting on the side of her bed with a wander alarm present to her right ankle. Resident #68 stated she didn't understand why she had the alarm on her ankle because "I never leave this room".

An interview occurred with Nurse #3 on 9/8/22 at

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10:40 AM, who was familiar with Resident #68. She explained Resident #68 rarely left her room and received all meals in her room. She had not witnessed her wandering in the hallways for "some time".

On 9/8/22 at 10:47 AM, NA #2 was interviewed. She was typically assigned to care for Resident #68 during the day shift (7:00 AM to 3:00 PM) and stated she rarely left her room. At times she would stand in her doorway or want to sit at the door way or hallway to watch staff and others. She added Resident #68 was able to ambulate with her walker or a wheelchair, but she had not witnessed her attempting to seek an exit from the facility.

A phone interview occurred on 9/8/22 at 1:30 PM, with Nurse #5 who worked as the weekend supervisor from 7:00 AM to 7:00 PM. He stated he was familiar with Resident #68 and had not witnessed her wandering in the building or exit seeking. Stated she rarely came out of her room.

On 9/8/22 at 2:33 PM, a phone interview was conducted with NA #3 who was familiar with Resident #68 and provided care to her in the evenings (3:00 PM to 11:00 PM). She stated Resident #68 stayed in her room and at the most would come to her doorway to request assistance or talk to staff. NA #3 stated Resident #68 was still alert and oriented but had some confusion at night.

NA #4 was interviewed via phone on 9/8/22 at 2:42 PM, stating she provided care to Resident #68 on the 7:00 PM to 7:00 AM shift. Stated Resident #68 normally only came to her doorway of her room to ask staff for assistance, to look up

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and down the hallways or to talk with staff as they passed by. NA #4 stated "about four months ago" Resident #68 walked to the memory care unit doors (on the same hallway that she resided on) looking for family and her purse, but she had not witnessed this behavior since. She denied Resident #68 came out and wandered in the facility or attempted to exit seek.

A phone interview was held with Nurse #6 on 9/9/22 at 9:56 AM. He stated he was familiar with Resident #68 and cared for her on the weekends 7:00 AM to 11:00 PM. Nurse #6 explained "95%" of the time she stayed in her room but would come up to the common area at the nurse's station but no longer was looking for things/people or exit seeking. Typically, though, she would come to her doorway or out in the hall looking around but found her way back to her room without any incidents. Nurse #6 stated he didn't consider these behaviors as wandering or exit seeking.

The Nurse Practitioner (NP) was interviewed on 9/8/22 at 12:50 PM, and reviewed the Elopement Risk Assessment form dated 8/25/22, showing there was no exit seeking behavior present. The NP stated Resident #68 still required the wander alarm because she walked out in the halls, she had seen her in the common area of the unit at times when she worked at night and added, "she could go into any of these rooms, and we wouldn't know where she was".

The Administrator was interviewed on 9/9/22 at 10:35 AM and stated when the NA's completed the behavior log there was an icon that popped up asking if the nurse had been made aware before they were able to complete what behaviors

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F 658	Continued From page 17 were present. She would expect if a resident exhibited behaviors, such as wandering, to be marked on the behavior log as well as in the nursing progress notes. She continued to explain the Elopement Risk Assessment forms, that were completed every three months, should be utilized to assess the need for continuation of a device such as a wander guard. A trial removal should have been discussed with the Interdisciplinary Team (IDT) since Resident #68 no longer displayed any wandering or exit seeking behaviors.	F 658		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to provide any scheduled activities on the weekends. This was for 3 (Resident #1, Resident #22 and Resident #4) of 3 residents reviewed for activities. The findings included: 1. Resident #1 was admitted on 6/21/21 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).	F 679	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 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	9/9/22

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F 679	Continued From page 18 Review of Resident #1 activities care plan initiated 6/21/21 read she participated in group activities and individual pursuits. Her quarterly Minimum Data Set dated 8/25/22 indicated she was cognitively intact. Review of Resident #1's Social Assessment dated 8/26/22 indicated she participated in the assessment and she was cognitively intact. She enjoyed individual pursuits such as needlework, social media and watching television. She also stated she was very social and participated in group activities. Review of the activity calendar for July, August and September 2022 revealed activities Monday through Friday. The calendars for Saturdays read family and friend visits and for Sundays included a picture of a church. An interview was completed on 9/8/22 at 4:15 PM with Resident #1. She stated there were no activities on the weekends. Observed in her room was a copy of the September 2022 activity calendar. When questioned about what the calendar read for Saturdays regarding family and friend visits, she stated it meant the only thing for that day was hopefully the residents would have a visitor come see them. When questioned about the picture of a church on Sundays, she stated it didn't mean anything. It was just a picture and that there were no services on Sundays but rather on Mondays. An interview was completed on 9/9/22 at 9:05 AM with Activity Director (AD) #1. She stated she was the AD for the 200 hall and AD #2 was	F 679	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: F679 It is the intent of this facility to provide an ongoing activities program that meets the interests of and supports the physical, mental and psychosocial well-being of each resident. 1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 9/21/2022, the Nursing Home Administrator spoke with resident #1 to inquire about her preferences for weekend activities. Resident #1 stated that she enjoyed doing her needlework and reading her tablet on weekends. She also stated that she enjoyed spending time with other residents and working the puzzles on the unit. She would enjoy church services on the weekend and did realize that there were church services	

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responsible for 400 and 500 halls. AD #1 stated AD #2 had been doing activities for a long time and she assisting with her training. She stated she worked Monday through Friday and AD #2 came in Monday through Friday at 11:00 AM. AD #1 stated AD #2 was responsible for the activity calendar each month and that to her knowledge, there were no scheduled activities on the weekends. When asked about Saturdays family and friends visits, it was a day for families to visit. When asked what the picture of a church meant on Sundays, she stated she thought it meant that there were church services on Sundays but she never inquired.

An interview was completed on 9/9/22 at 10:03 AM with AD #2. She stated she completed the monthly activity calendar and there were no scheduled activities on the weekends since COVID. She stated Saturdays was a day off for families to visit with the residents but if a residents wanted an activity to do, there was a cart the aides could pass around if a resident requested to do an activity. When questioned about the picture of a church on Sundays, she stated Sunday was a day of rest so no activities were scheduled. AD #2 stated they scheduled their church service on Mondays.

An interview was completed on 9/9/22 at 11:05 AM with the Administrator. She stated she was made aware today that there were no scheduled activities for the residents on weekends and offered no explanation as to why she was not aware. She stated it was her expectation that there be some sort of activities for the residents on the weekends.

that she could attend each Sunday. Resident #1 prefers that the church services be held in the Health Care Unit. Nursing Home Administrator informed resident #1 that our Chaplain would be able to begin Sunday Services in Health Care again on October 2, 2022.

On 9/21/2022 the Nursing Home Administrator spoke with resident #22 to inquire about her preferences for weekend activities. Resident #22 stated that she likes to rest on the weekends, enjoys going to the fishpond with her friends and making cards. When asked if she would like to see additional activities on weekends, she stated that she didn't know of anything but enjoys hearing gospel music. Nursing Home Administrator informed resident that our Chaplain would be able to resume Sunday worship again on October 2, 2022.

On September 21, 2022, the Nursing Home Administrator spoke with resident #4 to inquire what activities she would like to see on weekends. Resident #4 rarely attends activities during the week and prefers to remain in her room listening to her Alexa, watching television and visiting with her children and grandchildren. The Nursing Home Administrator asked resident #4 what activity she would like to attend on the weekend, she replied that she might attend a church service if her family was not here. The Nursing Home Administrator informed resident #4 that our Chaplain would resume worship services on October 2, 2022.

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F 679	Continued From page 20 2. Resident #22 was admitted 10/11/21 with a diagnosis of Parkinson's Disease. Review of Resident #22 undated activities care plan read she was a very social person, enjoyed worship services, gospel singing, Bible study and Bingo. Her quarterly Minimum Data Set dated 7/8/22 indicated she was cognitively intact. Review of Resident #22's Social Assessment dated 7/13/22 indicated she participated in the assessment and she was cognitively intact. She enjoyed worship services, gospel music and occasionally played Bingo. An interview was completed on 9/9/22 at 9:05 AM with Activity Director (AD) #1. She stated she was the AD for the 200 hall and AD #2 was responsible for 400 and 500 halls. AD #1 stated AD #2 had been doing activities for a long time and she assisting with her training. She stated she worked Monday through Friday and AD #2 came in Monday through Friday at 11:00 AM. AD #1 stated AD #2 was responsible for the activity calendar each month and that to her knowledge, there were no scheduled activities on the weekends. When asked about Saturdays family and friends visits, it was a day for families to visit. When asked what the picture of a church meant on Sundays, she stated she thought it meant that there were church services on Sundays but she never inquired. An interview was completed on 9/9/22 at 10:03 AM with AD #2. She stated she completed the monthly activity calendar and there were no scheduled activities on the weekends since	F 679	2) How the facility will identify other residents having the potential to be affected by the same deficient practice Each month, during resident council, the residents are asked if they have any suggestions for activities (do they want something added, something changed, etc.) Beginning 9/19/2022, each of our Homemaker Guides will interview residents to ascertain what, if any, group activities residents would like to participate in on the weekends. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Administrative staff have approved the purchase of a multitude of activity supplies that have been made available to our residents for use during the week and on weekends. Weekend staff will continue to engage residents in these activities: Staff take residents outside Play cards, Work puzzles, Spend time in residents□ rooms visiting, Make special snacks (strawberry shortcake, ice cream sundaes, etc..) for all our residents. Paint fingernails	

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F 679	Continued From page 21 COVID. She stated Saturdays was a day off for families to visit with the residents but if a residents wanted an activity to do, there was a cart the aides could pass around if a resident requested to do an activity. When questioned about the picture of a church on Sundays, she stated Sunday was a day of rest so no activities were scheduled. AD #2 stated they scheduled their church service on Mondays. An interview was completed on 9/9/22 at 11:38 Am with Resident #22. She stated there were no activities on the weekends but she wished there was something she could attend other than just visiting other residents. An interview was completed on 9/9/22 at 11:05 AM with the Administrator. She stated she was made aware today that there were no scheduled activities for the residents on weekends and offered no explanation as to why she was not aware. She stated it was her expectation that there be some sort of activities for the residents on the weekends. 3. Resident #4 was originally admitted to the facility on 5/6/21 with diagnoses that included end stage renal disease (ESRD). The most recent Minimum Data Set (MDS) assessment dated 5/30/22 indicated Resident #4 was cognitively intact. An interview was completed on 9/9/22 at 9:05 AM, with Activity Director (AD) #1, who worked Monday through Friday. She stated she was the AD for the 200 hall, some of the 300 hall residents and AD #2 was responsible for the 400 and 500 halls. AD #1 stated AD #2 had been doing activities for a long time and had been providing training to her. She explained AD #2	F 679	As the COVID-19 county transmission rate declines, we will invite outside groups back into our facility. Since we now have three (3) staff members available to conduct weekend activities for the first time in greater than four (4) months, our activities staff will begin a weekend rotation to provide more group activities for the residents. Ideas from the resident surveys will continue to be incorporated into our monthly Activities Calendar. 4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. These corrective measures will be monitored by the Social Worker with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Social Worker will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most	

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F 679	Continued From page 22	F 679		

was responsible for the creating the activity calendar each month and that, to her knowledge, there were no scheduled activities on the weekends. When asked about the event scheduled for Saturdays (family and friends visits), it was a day for families to visit. When asked what the picture of a church meant for the scheduled event on Sundays, she stated she thought it meant that there were church services on Sundays, but she had never ever inquired.

An interview was completed on 9/9/22 at 10:03 AM with AD #2, who stated she worked Monday thru Friday, coming in at 11:00 AM. She explained she created the monthly activity calendar and there were no scheduled activities on the weekends since the COVID-19 pandemic. She stated Saturdays were a day off for families to visit with the residents but if a resident wanted an activity to do, there was a cart that the aides could pass around for them to choose from. When questioned about the picture of a church on the calendar for Sundays, she stated "Sunday was a day of rest", so no activities were scheduled. AD #2 stated they church services were scheduled on Mondays.

Resident #4 was interviewed on 9/9/22 at 10:50 AM. She explained she participated in activities through out the week but there were no activities scheduled for the weekends. She added, "It would be nice so I could get out of the room on the weekends".

An interview was completed on 9/9/22 at 11:05 AM, with the Administrator. She stated she was not aware that there were no activities being provided for the residents on the weekends, but it was her expectation that there be some sort of appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.

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F 679	Continued From page 23 activities scheduled.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to ensure alternating pressure reducing mattresses were set according to the residents' weight for 2 of 3 residents reviewed for pressure injuries (Resident #62, and Resident #14). The findings included: 1. Resident #62 was admitted on 3/3/2022 with diagnoses that included pressure ulcer to the sacrum. Resident #62's quarterly Minimum Data Set (MDS) dated 8/15/2022 indicated the resident was moderately cognitively impaired, required extensive assistance for activities of daily living and was incontinent of bowel and bladder. The resident was coded with one stage 2 pressure	F 686	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 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	9/28/22

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F 686	Continued From page 24 injury during the assessment period. Resident #62's comprehensive care plan was last updated 8/17/2022 and included a focus for pressure injuries. Interventions for prevention of worsening of existing pressure injuries and prevention of new pressure injuries included use of alternating pressure reducing mattress. The resident's medical record indicated she was 98.4 lbs on 9/1/2022. Resident #39's Treatment Administration Record (TAR) for August 2022 indicated the resident was to have a pressure reducing air mattress and the TAR was signed off by the assigned nurse twice daily. On 9/07/2022 at 11:50 PM an interview was conducted with Nurse #4. She stated the facility did not have a wound treatment nurse; the nurses assigned to the resident performed wound care. She stated she was assigned to Resident #62 and was familiar with her history of pressure injuries. She further stated the resident's skin was intact and they were applying a barrier ointment to the newly healed area on her sacrum. On 9/7/2022 at 12:00 PM the resident's pressure reducing mattress was observed to be set on 200 pounds (lbs). The control panel indicated the setting should be set to the occupant's weight. A second interview was conducted with Nurse #4 on 9/07/2022 at 3:43 PM. Nurse #4 observed the resident's pressure reducing mattress set at 200lbs. She stated she did not know why the mattress was set for 200 lbs, the resident was less than 100lbs. She further stated the nurses	F 686	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: F686 It is the intent of this facility to ensure the correct setting for alternating pressure reducing mattresses. 1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 9/9/2022, the Director of Nursing changed the settings according to their respective weights for Resident #14 and Resident #62's alternating pressure reducing mattresses. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice On 9/9/2022 the Director of Nursing inspected the setting for the remaining one (1) resident on an alternating pressure reducing mattress for accuracy. 3) What measures will be put into place or systemic changes made to ensure that	

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F 686	Continued From page 25 were responsible for making sure the pressure reducing mattresses are set and functioning properly. She did not know how the setting got changed. She had checked the mattress for functioning but had not checked the settings. An interview was conducted with the DON on 9/9/2022 at 1:00 PM. She stated alternating pressure reducing mattresses should be set to the resident's weight and the nurses assigned to the residents are responsible for checking the mattress for accurate settings and proper functioning. 2. Resident #14 was admit on 12/31/21 with a pressure ulcer and readmitted on 6/24/22 with a left hip fracture and a pressure ulcer to her sacrum. Review of Resident #14's pressure ulcer care plan initiated 6/24/22 included the intervention of an pressure relieving air mattress to her bed. Review of Resident #14's significant change Minimum Data Set dated 6/30/22 indicated she was cognitively intact, coded for one stage 3 pressure ulcer and a pressure relieving device on the bed. Review of a Physician order dated 7/12/22 read Resident #14 was prescribed an alternating pressure mattress (APM) with a pump. The order read the staff were to check the function and therapeutic range of the air mattress on each shift. Review of Resident #14's Treatment Administration Records for 07/12/22 through 09/08/22 indicated the nurses checked the function of her APM twice daily.	F 686	the deficient practice will not recur All residents requiring alternating pressure reducing mattresses will have an order that includes the proper setting. Licensed nurses will sign off the order twice a day indicating that they visualized the air mattress setting. Also, a sticker with the appropriate setting will be attached to the air mattress control box informing all staff of the appropriate setting. The Assistant Director of Nursing or her designee will audit for compliance daily Monday through Friday and the Weekend Shift Coordinator will audit for compliance Saturday and Sunday for two (2) weeks and once weekly for an additional three (3) months 4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. These corrective measures will be monitored by the Assistant Director of Nursing with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Assistant Director of Nursing will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further	

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F 686	Continued From page 26 A review of Resident #14's electronic medical record indicated a weight of 113.6 pounds on 9/3/22. An observation was completed on 9/6/22 at 11:47 AM. Resident #14 was lying in bed. She confirmed she had a pressure ulcer to her sacral. She stated she did not like the mattress the facility provided. The APM pump was attached to the footboard of her bed. The APM was set for a weight of 400 pounds. Another observation was completed on 9/7/22 at 2:32 PM. Resident #14 was again lying in bed with the weight setting to her APM at 400 pounds. An interview was completed on 9/7/22 at 3:32 PM with Nurse #1. She stated the nurses were to check for inflation and the pump settings on every 12 hour shift and documented it on the TAR. An observation was completed on 9/7/22 at 3:35 PM with Nurse #1. She noted the APM weight setting was set for 400 pounds. Nurse #1 stated she checked it daily for inflation but she should also be checking the weight setting. She adjusted the weight setting on the APM to the proper setting for Resident #14's actual weight. An interview was completed on 9/8/22 at 11:10 AM with Nursing Assistant (NA) #2. She stated the aides were not allowed to adjust any settings on the APM because it was the responsibility of the nurse. An interview was completed on 9/9/22 at 12:45 PM with the Director of Nursing (DON). She stated Resident #14's APM weight setting should be set as near to her actual weight as possible	F 686	recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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F 686	Continued From page 27 and checked on every shift to ensure accuracy.	F 686		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		9/28/22

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F 758	Continued From page 28 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews with staff, Pharmacy Consultant, Nurse Practitioner (NP) and Psychiatric Mental Health Nurse Practitioner (PMHNP), the facility failed to attempt a gradual dose reduction (GDR) for a resident who received two antipsychotic medications for 1 of 5 reviewed for unnecessary medications (Resident #71). The findings included: Resident #71 was admitted on 6/3/2022 with diagnoses that included Parkinson's disease with Parkinson's psychosis, dementia, depression, and anxiety. Resident #71's quarterly Minimum Data Set (MDS) dated 6/10/2022 indicated the resident was cognitively intact, required extensive assistance with activities of daily living, and received antidepressants 7 out of 7 days, antipsychotics 7 out of 7 days, antianxiety medications 7 out of 7 days and opioids 2 out of 7 days during the assessment period.	F 758	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 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.	

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F 758	Continued From page 29 The resident's comprehensive care plan dated 9/6/2022 included a focus for risk of adverse reactions from psychotropic medications. Resident #71's medical record had one abnormal involuntary movement scale screening (AIMS) dated 6/13/2022. The resident's calculated AIMS score was 14. The AIMS form included interpretation of AIMS score and read as follows: score of 0-7 there is a low risk of movement disorder, 8 is a borderline risk of movement disorder, and a score of 9 or greater should be referred to neurology for neurological exam. The resident's active orders included: Lorazepam (antianxiety medication), 1 milligram (mg) orally 3 times a day with a start date of 8/12/2022 and no end date. Nortriptyline (antidepressant medication)20 mg at bedtime with a start date of 8/12/2022 and no end date. Sertraline (antidepressant medication), 50 mg orally daily with a start date of 8/12/2022 and no end date. Nuplazid (atypical antipsychotic prescribed for Parkinsons psychosis), 34 mg daily with a start date of 8/12/2022 and no end date. Quetiapine (antipsychotic medication), 25 mg at night with a start date of 8/12/2022 and no end date. Resident #71 was seen by Psychiatric Mental Health Nurse Practitioner (PMHNP) on 6/21/2022. The PMHNP's summary indicated there were no psychotic symptoms noted or	F 758	Prefix Tag: F758 It is the intent of this facility to attempt a gradual dose reduction for residents receiving psychotropic medications per CMS requirements. 1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #71 went to the Neurologist on 9/12/2022 and returned with no recommendation to reduce any psychotropic medications secondary to Resident #71 being on an antibiotic. On 9/20/2022, Resident #71 was evaluated by our consultant psychiatric service provider, and a recommendation was made to discontinue Resident #71's Seroquel. On 9/21/2022, our Medical Director discontinued the morning dose of Seroquel. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice On 9/13/2022, the Nursing Home Administrator requested a listing of all residents currently on psychotropic medications from our Pharmacy Consultant with the latest gradual dose reduction attempt	

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F 758	Continued From page 30 reported, the resident denied auditory or visual hallucinations, and the resident was not responding to internal stimuli. The PMHNP's recommendations included gradual dose reduction of quetiapine in next 4-8 weeks after resident adjusted to facility. Patient was at risk for adverse effects from polypharmacy of multiple antipsychotics, multiple antidepressants, and multiple sedating agents. She also recommended referral to neurology. Resident #71's behavior monitoring log, provided by the facility, for July, August, and September revealed there were no behaviors documented by staff. The medical record included monthly medication reviews (MMR) by the consulting pharmacist. A MMR dated 7/29/2022 recommended GDR of quetiapine. A MMR dated 8/30/2022 also recommended a GDR of quetiapine. Resident #71's medical record revealed a second dose of Quetiapine (antipsychotic medication), 12.5mg orally in the morning was added by Nurse Practitioner (NP) #1 on 9/5/2022 with no end date. An observation of Resident #71 was conducted on 9/6/2022 at 3:01 PM. She was observed in her room, sitting up in bed with eyes closed. She had continuous movement of her mouth and tongue. Resident did not respond when spoken to. A second observation was conducted 9/07/2022 at 10:50 AM. The resident was observed in her room seated in a recliner. Again, she was observed to have continuous movement of the mouth and tongue.	F 758	This list was compared to each resident's active medication list. Visit summary notes from our Medical Director and our Nurse Practitioners were read by the Nursing Home Administrator and Director of Nursing. Those residents that had not had an appropriate gradual dose reduction were placed on a list for either our Medical Director to evaluate or our Consultant Psych Provider to evaluate. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Nursing Home Administrator (NHA) and Director of Nursing (DON) placed a behavior monitoring order in for each resident that has an order for a psychotropic drug as well as a mood-altering medication. On 9/20/2022, the NHA and DON met with our Consultant Psych Provider to discuss how this facility would handle her recommendations for gradual dose reductions moving forward. Recommendations will be addressed to our Medical Director and placed at the bottom of her notes. On 9/21/2022, the NHA and DON met with our new Medical Director and educated her about the regulations surrounding gradual dose reductions and	

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F 758	Continued From page 31 On 9/08/2022 at 1:00 PM an interview was conducted with NP#1. She stated she was familiar with Resident #71. She further stated she was aware the resident was on two antipsychotics, two antidepressants and an antianxiety medication and stated she needed every bit of it and probably more. When asked why, she stated the resident had been "off the chain" recently. NP#1 described visual and auditory hallucinations by Resident #71. When asked, she stated she did not believe the resident received Psych services after 6/21/2022 and she did not know if the resident had seen neurology yet. When asked about signs of tardive dyskinesia (involuntary movement that can be a side effect of antipsychotic use) she stated the resident came in that way and was sure it had not gotten any worse since her admission. When asked if she was aware the resident had an AIMS of 14, she stated she was not aware the resident's AIMS was 14. On 9/08/2022 at 2:17 PM an interview was conducted with Nurse Aide #6 (NA). She stated she was very familiar with Resident #71 and was assigned to her. She further stated the resident has had auditory and visual hallucinations. However, the kiosk where they document behaviors required you to choose from a list of behaviors and hallucinations was not a behavior listed. She stated she made the nurse aware of the behaviors when they occurred. A telephone interview was conducted with the Pharmacy Consultant on 9/09/2022 at 11:40 AM. The pharmacist stated she reviewed the psych note on 6/21/2022, MARs, and the behavior	F 758	that moving forward all gradual dose reductions would be performed by her. All residents that are administered psychotropic medications as well as mood altering medications will be evaluated during each regulatory visit performed by our Medical Director. 4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. These corrective measures will be monitored by the Director of Nursing with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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F 758	Continued From page 32	F 758		

monitoring, prior to recommending a GDR of quetiapine. The resident had been started on Nuplazid which is appropriate for Parkinson's psychosis. She stated the recommendation was made in July and August and she had not received a response from the MD or NP regarding those recommendations. Additionally, she was not aware the NP had increased the quetiapine to twice daily from once daily. It was added after her last review on 8/30/2022.

On 9/09/22 at12:33 PM an interview was conducted with the Administrator. She stated the facility had recent challenges filling the position of Medical Director (MD) after their last MD retired the end of April 2022. On 8/16/2022 the Administrator became aware the GDRs were not addressed for all residents. She asked that pharmacy recommendations not be printed and given to the NP but the new medical director. The new MD took over resident care responsibilities on 8/30/2022 and was still getting to know the residents and addressing their GDRs. She further stated Resident #71 had a neurology appointment scheduled on 10/30/2022 but the called and were able to get it moved up to September.

A telephone interview was conducted with the PMHNP on 9/12/2022 at 8:00 AM. She stated she saw Resident #71 last on 6/21/2022. She had not been asked to see the resident since. She was not made aware of the increase in quetiapine made by NP#1 on 9/3/2022. It was her recommendation on 6/21/2022 they attempt a GDR of the quetiapine. She further stated she was concerned about polypharmacy in the resident due to the number of antipsychotic and psychotropic medications she received.

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F 758	Continued From page 33 An interview was conducted with the Director of Nursing and the Administrator on 9/9/2022 at 1:00 PM. The Administrator and the DON stated it was their expectation the NP, MD, and Consulting Pharmacist communicate and conduct GDRs when appropriate.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to report a medication	F 761	Preparation and execution of this plan of correction in no way constitutes an	9/28/22

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F 761	Continued From page 34 refrigerator temperature as out of range for 1 of 2 medication refrigerators reviewed (200-hall medication refrigerator). Findings included: The facility's Medication Policy and Procedure, last revised 10/2017 was reviewed. In the Medication Storage in the Facility section, under Temperature, item C indicated "Medications requiring refrigeration are kept in a refrigerator at temperatures between 2°C (centigrade) (36°F) and 8°C (46°F) with a thermometer to allow temperature monitoring...." On 9/08/22 at 2:34 PM the 200-hall medication room was observed. The medication refrigerator was opened, and the thermometer was observed with Medication Aide (MA) #1 and read 34 degrees (°) Fahrenheit (F). The MA stated she did not check the medication refrigerator or temperatures because she did not administer insulin. The contents of the refrigerator included: 3 Insulin Glargine pens 100 units (U)/1 milliliter (ml), 3 ml size 6 Insulin Lispro pens 100 U/1 ml, 3 ml size Information for both insulin glargine and insulin lispro pens was reviewed and indicated to keep new pens in the refrigerator between 36°F to 46°F, do not freeze, do not use if insulin has been frozen. The refrigerator log noted as "Sept. 2022" included instructions at the top of the sheet: "Temperature in degrees Fahrenheit-notify maintenance and DON (Director of Nursing) if not between 36 and 46 degrees."	F 761	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 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: F761 It is the intent of this facility to maintain medication refrigerator temperatures within range. 1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 9/8/2022, all medications in the refrigerator were removed by the Director of Nursing and new medications were ordered.	

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F 761	Continued From page 35 Temperature documentation included: 9/3/22 noted as 32°F 9/4/22 noted as 34°F 9/5/22 noted as 30°F An interview was conducted with Nurse #1 on 9/08/22 at 3:03 PM. The nurse stated the night shift checked the medication refrigerator temperatures. She explained unopened insulin was kept in the refrigerator and she did not look at the temperatures. An interview was conducted with the Director of Nursing (DON) on 9/08/22 at 3:48 PM. The DON stated when the nurse had observed the medication refrigerator temperature was below the recommended range, she would have expected the nurse to move the medications to another medication refrigerator and notify maintenance. The DON reviewed the maintenance log and stated she did not see any concerns regarding medication refrigerators noted.	F 761	On 9/8/2022, the Director of Nursing directed the third shift Charge Nurse to place the ordered medications into another medication refrigerator. On 9/9/2022, Maintenance checked the refrigerator that was out of temperature range and determined that the setting had been turned the incorrect way to correct the temperature. The refrigerator was turned to the correct setting and after 24 hours, the medications were returned to the appropriate refrigerator. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice On 9/9/2022, Maintenance checked all medication refrigerators and found them within range. Maintenance also marked the correct setting on all medication refrigerators to avoid confusion. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On September 23, 2022, the Administrator updated the refrigerator log to put the temperature range in red and to add verbiage reminding staff to remove medications if the temperature cannot be corrected and place into another medication refrigerator. Also added to temperature log was a place for the staff member leaving their	

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F 761	Continued From page 36	F 761	shift and the staff member coming onto shift to initial that the temperature is within range. Each day, beginning 9/23/2022, the Staffing/Purchasing Coordinator will audit the medication refrigerators Monday through Friday and the Shift Coordinator will audit the refrigerators on Saturday and Sunday for a period of two (2) weeks and then weekly for a period of two (2) months. 4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. These corrective measures will be monitored by the Director of Nursing with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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F 880	Continued From page 37	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		10/10/22

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F 880	Continued From page 38 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and interviews the facility failed to don personal protective equipment (PPE) when entering a room on transmission-based precautions (TBP) for 1 of 1 resident (Resident #39) reviewed for transmission-based precautions. The findings included:	F 880	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 submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from	

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F 880	Continued From page 39 The facility's Infection Prevention and Control Manual for Long Term Care, last revised 2/2/2022, indicated when a resident is on contact precautions, gloves and isolation gowns should be utilized and healthcare staff should don gloves and isolation gown before contact with the resident or his/her environment. Resident #39 was admitted on 8/27/2022 with diagnoses that included pneumonia. The resident's medical record contained a progress note by Nurse Practitioner (NP) #1. The NP saw the resident on 9/1/2022 for a rash characterized as vesicular lesions of the right flank and right breast that was highly suggestive of Herpes Zoster (Shingles). Resident #39 was placed on antiviral Valtrex and TBP, contact isolation. On 9/6/2022 Resident #39 was observed to be on transmission-based precautions with signage on door indicating contact precautions. The sign indicated anyone entering the room should perform hand hygiene, don gown and gloves prior to entering the room. There was a PPE caddy with supplies outside the resident's door. On 9/07/2022 at 11:54 AM Nurse Assistant (NA) # 1 was observed entering Resident #39's room. The resident was observed sitting in her wheelchair receiving an aerosolized nebulizer treatment. NA#1 entered the room in her scrubs and face mask, without donning PPE. The NA was interviewed after she exited the room and stated the resident was on precautions for shingles. When asked why she did not don PPE, she stated she was only in the room briefly. She further stated she should have worn a gown and	F 880	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: F880 It is the intent of this facility to conduct an annual review of its IPCP and update the program as necessary. 1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 9/9/2022, Resident #39 was taken off Transmission Based Precautions. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice Residents will be identified by the need for Transmission Based Precautions. 3) What measures will be put into place or	

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F 880	Continued From page 40 gloves when she entered the room since the resident was on contact precautions. An interview was conducted with the Director of Nursing (DON)/Infection Control Preventionist on 9/9/2022 at 1:00 PM. She stated staff should wear PPE in rooms with residents who are on contact precautions.	F 880	systemic changes made to ensure that the deficient practice will not recur On September 19, 2022, members of our QAPI team including our Director of Nursing/IP, our Assistant Director of Nursing and our Shift Coordinators met to begin a Root Cause Analysis. In conjunction with our Medical Director, the Assistant Director for SPICE as well as a member of our Governing Body, we established the Root Cause for this incident Education will be given by our Director of Nursing/Infection Preventionist utilizing SPICE education for staff members that enter residents rooms that are on Transmission Based Precautions. Education will include proper indication for Transmission Based Precautions as well as proper Personal Protective Protection for each precaution. This education will be added to our orientation for newly hired clinical staff. A shift away from monthly PPE audits focusing mainly on Enhanced Precautions for COVID-19 will begin in October 2022 toward inclusion of PPE for all Transmission Based Precautions. 4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. These corrective measures will be	

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F 880	Continued From page 41	F 880	monitored by the Director of Nursing/IP with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing/IP will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner. The Directed Plan of Correction will be completed by October 10, 2022	