PRINTED: 05/09/2018 FORM APPROVED

Division of Health Service Regulation

	E CORRECTION I IDENTIFICATION NUMBER		(X3) DATE SURV COMPLETED			
			A. BUILDING: _		R	
		HAL018035	B. WING		05/03/2	018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIEDMON	T VILLAGE AT NEWTON	1345 CHAF NEWTON,	PMAN LANE			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETE DATE
D 000	Initial Comments		D 000			
		artment of Social Services and follow-up survey on				
D 074	10A NCAC 13F .0306 Furnishings	S(a)(1) Housekeeping And	D 074			
	10A NCAC 13F .0306 Furnishings (a) Adult care homes (1) have walls, ceiling coverings kept clean	s shall: gs, and floors or floor				
	failed to assure the w 2 common shower are of the halls, were kep as evidenced by stain shower room walls, m around the baseboard plastic and metal fixtu and brown stained an 2 of 4 common bathr stains and smears on buildup around the to large piece of porcela	als, floor and fixtures in 2 of eas, in Zone 3 and Zone 5 t clean and in good repair, as and smears on the hold and mildew buildup ds, tile and toilet, a broken are on the wall in Zone 5, and damaged privacy curtains; nooms in Zone 3 and 5 had a the walls, mold and mildew ilet and baseboards and a hin broken from the sink rim resident rooms in Zone 2				
	The findings are:	o facility tour on 05/00/40 -4				
	Observation during th	e facility tour on 05/02/18 at]			

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
					R
		HAL018035	B. WING		05/03/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
PIEDMON	T VILLAGE AT NEWTON		APMAN LANE		
		NEWTON	N, NC 28658		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 074	Continued From page	: 1	D 074		
	-One common showe and a ladies bathroon and in Zone 5The resident rooms v. Zone 3 and Zone 5. Observation of the co 5 on 05/02/18 at 10:1The toilet, baseboard	d the facility into 5 zones. r room, a men's bathroom n were located in Zone 3 vere located in Zone 2, mmon shower room in Zone 8am revealed: Is and floor tiles had an			
	the faucet to the base placed over the side of tub. -There was a broken hardware exposed on -A box of tiles, an ope and plastic fixtures, we the right of the bathtul dust build up and dirt, dead bugs.	the porcelain bathtub from a for the tub, and from a hose of the tub to the drain of the plastic fixture with metal the wall next to the toilet. In bag of "Sanded Grout", ere under a bath chair, to b, surrounded by a thick black mold staining and			
	stained and moldy, withe top damaged. Observation of room of 7:45am revealed; -3 large black stains a stains were on the research bed comforter had the smell of urine was	holes and frayed edges. as evident in the room. ower room in Zone 3 on			

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 2 of 14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN C	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL018035	B. WING		R 05/03/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DIEDMON	T VILLAGE AT NEWTON	1345 CHA	PMAN LANE		
PIEDWON	I VILLAGE AT NEWTON	NEWTON	NC 28658		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 074	Continued From page	2	D 074		
	the toilet and the base -There was brown sta walls.	eboard of the walls. nining and streaks on the tain had brown staining and			
	05/03/18 at 9:05am re	elain was missing from the asin. iining on the walls ildup and mold on the			
	10:15am revealed: -She worked 6 hours FridayShe was the only how housekeeper on the vealure of the vealure o	e for cleaning the resident's on areas, including the lity of the staff on second orm light duty cleaning in the le to complete during the supplies locked in the en she finished her shift, for se get into the bathrooms to use the residents are using the debris (a bag of sanded plastic fixtures) in the (Zone			

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 3 of 14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMP	LETED
		HAL018035	B. WING			R / 03/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
DIEDMON	T VILLAGE AT NEWTON	1345 CH	APMAN LANE			
PIEDWON	T VILLAGE AT NEWTON	NEWTON	, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 074	Continued From page	e 3	D 074			
		and floor. "I can not get to				
	Interview with a resid revealed:	ent on 05/03/18 at 10:25am				
	was dirty.	t the shower area in Zone 5 e 5 shower room on his				
	designated days"It's OK (the shower	room) I guess."				
	the Assistant Adminis facility was maintaine manner. -The corporate maint remodeling the facility	revealed: lity of the housekeeper and strator (AA) to assure the d in a clean and safe enance staff have been y "room by room."				
	-This was an "on-goir -She would follow up and the AA regarding	with the maintenance staff				
	05/03/18 at 10:47am -"That shower room v	vas always dirty. The do a good job cleaning."				
	Interview with the AA revealed: -She gave the housel responsibilities.	on 05/03/18 at 10:55am keeper a list of				
	-She walked through basis and did not noti -The cleaning tasks, I day shift, should be fi staff between 9:00pm	not completed during the nished by the evening care				

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 4 of 14

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL018035	B. WING		R 05/03/2018
	ROVIDER OR SUPPLIER T VILLAGE AT NEWTON	1345 CH	DDRESS, CITY, STAT APMAN LANE I, NC 28658	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 074	-She replaced the begin some of the resider move residents and control of the hold of the other end of the hold of the hall of the hold of	and the evening staff. droom rugs with tile flooring ht's rooms. It took time to contact their guardians. resident on 05/03/18 at expreferred the shower at all (in Zone 3) since it was resident on 05/03/18 at expression to 05/03/18 at expression the 05/03/18 at expression to	D 074		
D 113	10A NCAC 13F .0311 (d) The hot water sys provide an adequate skitchen, bathrooms, la closets and soil utility	stem shall be of such size to supply of hot water to the aundry, housekeeping	D 113		

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 5 of 14

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL018035	B. WING		0:	R 5/03/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
DIEDMON	IT VII I ACE AT NEWTON	1345 CH	APMAN LANE			
PIEDWON	IT VILLAGE AT NEWTON	NEWTO	N, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 113	be maintained at a mi (38 degrees C) and s	e 5 inimum of 100 degrees F hall not exceed 116 degrees This rule applies to new and	D 113			
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility fa temperatures betwee Fahrenheit (F) in the	ns, interviews and record illed to maintain hot water n 100-116 degrees common shower rooms, and men's bathrooms.				
	The findings are:					
		s resident roster on 05/02/18 6 residents were currently				
	on 05/02/18 revealed -Between resident roo there was a women's bathroom and a wom	om 8 and resident room 9 shower room, a men's en's bathroom. om 13 and resident room 14 ower room, a men's				
	9:30am to 9:50am rev -The water temperatu women's common sho (F). -The water temperatu	18 at various times between wealed: ure at the sink in the ower room was 122 degrees ure at the sinks in the men's 2) was 122 degrees (F).				

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 6 of 14

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL018035	B. WING		0.5	R 5/03/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	-	
		1345 CH	APMAN LANE	•		
PIEDMON	IT VILLAGE AT NEWTON	I NEWTOI	N, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 113	women's bathroom woodservation of the As on 05/02/18 at 9:45a temperature gauge of the construction of the	vas 122 degrees (F). ssistant Administrator (AA) m revealed she adjusted the n the hot water tank. common bathroom and on 05/02/18 at 9:50am N: HOT WATER!!!" sign had athroom and shower room on 05/02/18 at 9:46am nance staff monitored the hot once a month. vater tank for the resident's and shower rooms. Is current Health Department pection report on 05/02/18	D 113			
	1 point deduction for water between 100 d -On the comment add	e 100-116 deg F hot water in				
	Review of the facility' 05/02/18 revealed: -"Baths 110.3, showe on 01/01/18"Baths 108.6, showe on 02/04/18"Baths 107.3, showe on 03/07/18.	ers 108.6" was documented ers 107.6" was documented ers 106.9" was documented				

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 7 of 14

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL018035	B. WING		05/03/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PIEDMON	T VILLAGE AT NEWTON	1345 CHA	PMAN LANE		
1 ILDINION	T VILLAGE AT NEWTON	NEWTON	NC 28658		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 113	Continued From page	e 7	D 113		
	bathroom between ro	ndwashing sink in the men's oms 8 and 9 on 05/02/18 at ot water temperature of 112			
	shower room doors or revealed the "CAUTION"	ommon bathroom and n 05/03/18 at 8:00am DN: HOT WATER!!!" signs ill bathroom and shower			
	Interviews with 19 res 10:00am to 12:00pm revealed: -5 residents stated the comfortable or very "c -3 residents stated the was warmer than the They preferred the ter -1 resident stated "I lil It is not too hot or cold anyone complain of the Another resident indit the temperature of the fine". She had no com -9 residents felt the w showers was not too -1 resident stated "my Another stated "my venough"1 stated "my water is	sidents on 5/2/2018 from and from 2:00pm to 4:00pm to 4:			
	my shower". -1 stated "I think my v	vater is good, I have only			

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 8 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7.1. 50.25.1.10.		F	?
		HAL018035	B. WING		1	3/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PIEDMON	T VILLAGE AT NEWTON		MAN LANE			
	Г	NEWTON,	NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 113	Continued From page	e 8	D 113			
	-Another stated "my v I like it".	vater is hot for showers, how				
	on 05/03/18 at 9:03ar -He checked the hot value of times" per r -He was at the facility inadvertently "bumpe the hot water tank whather oomHe was aware of the between 100-116 deg. Interview with the AA revealed: -The maintenance state hot water temperative was considering checking hot water teshe intended to begit temperatures during the maintenance staff water the hot water the water the staff water the hot water the hot water the by the Health Departrimmediately adjusted the hot water tank. Si	water temperatures "a month. on 04/29/18 and may have d" the temperature gauge on len moving items around in rule requiring a range grees (F). on 05/03/18 at 8:15am aff checked and documented latures on a monthly basis. aff worked part time at the lincreasing the frequency of increasing the frequency of inchecking hot water those times when is not in the building. Itemperature was identified				
	rangeThey would continue temperature is within -She was aware of th between 100-116 deg	to monitor until the range. e rule requiring a range grees (F). nad complained to her about				
	Interview with the Adr 10:37am revealed:	ministrator on 05/03/18 at				

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 9 of 14

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL018035	B. WING		05/03/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PIEDMON	T VILLAGE AT NEWTON		PMAN LANE , NC 28658		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 113	-She was aware of the between 100-116 deg-The maintenance statemperature on a moral are	e rule requiring a range prees (F). Iff monitored the hot water partially basis. If the AA will notify the partial contractor will be called to prepairs. If the issue with the AA and the temperatures within the partial common precedent in the common precedent precedent in the common precedent in the common precedent in the common precedent pre	D 113		
D 287	10A NCAC 13F .0904 Service	(b)(2) Nutrition And Food	D 287		
	(b) Food Preparation Homes: (2) Table service shal non-disposable place a knife, fork, spoon, p	Nutrition And Food Service and Service in Adult Care I include a napkin and setting consisting of at least late and beverage s may be made on an			

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 10 of 14

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SL (X3) DATE SL (X4) PROVIDER/SUPPLIER/CLIA (X4) MULTIPLE CONSTRUCTION (X5) DATE SL (X6) PROVIDER/SUPPLIER/CLIA (X6) MULTIPLE CONSTRUCTION (X6) DATE SL (X6) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) DATE SL (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) DATE SL (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) DATE SL (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/SU					
			71. 501251110.			R
		HAL018035	B. WING		05	5/03/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
DIEDMON	T VII I A CE AT NEWTON	1345 CH	APMAN LANE			
PIEDMON	IT VILLAGE AT NEWTON	NEWTO	N, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 287	Continued From page	e 10	D 287			
	individual basis and s documented needs o resident.	hall be based on				
	reviews, the facility fa included a non-dispos	ns, interviews and record iled to assure table service				
	The findings are:					
	between 12:25pm to -There were 23 resideroomThe meal served to rechicken breast, steam tomatoes, biscuit and -The place setting for a knifeTwo personal care a meal to the residentsTwo residents picked ate it with their fingersOne resident used the cut the chicken into s	residents included baked ned vegetables, stewed chocolate pudding. all residents did not include ides (PCA) delivered the d-up the chicken breast and s. neir fingers and the fork to				
	revealed: -She went table-to-tal required any assistan needed their chicken	on 05/02/18 at 12:45pm ole asking residents if they ce with their meal or if they breast cut into pieces. yed cutting the chicken ats.				
	Observations of the b	reakfast meal on 05/03/18				

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 11 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
			D WING		R
		HAL018035	B. WING		05/03/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PIEDMON	T VILLAGE AT NEWTON		PMAN LANE		
		NEWTON,	NC 28658		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 287	Continued From page	e 11	D 287		
	between 7:30am to 8 -There were 24 resideroomThe meal served to rscrambled eggs, toas cerealThe place setting for a knife. Observation of the dierefrigerator door in the 12:30pm revealed: -All residents were listing diet.	ents seated in the dining residents included t, canned pears and cold all residents did not include et orders posted on the e kitchen on 05/02/18 at ted as being on a regular			
	Interviews with seven between 2:45pm to 4 -One resident stated: Staff "always" asked I they wanted their food chicken on the biscuit There "never" had be thought it was "so no -One resident stated me but it's pretty soft [that there was no kni -"My food is soft or th -The resident who ate the chicken breast stapudding today, I didn' up people stuff if need -"They ask me if I war -"I need help cutting re"They don't put knive -"They don't allow kni needed""This doesn't bother	residents on 05/02/18 :10pm revealed: she did not need a knife. her and the other residents if d cut. Today she "put the t" and ate it like a sandwich. en a knife at the table. She one got hurt". that "they cut my food for mostly, doesn't bother me" fe]. ey will cut it up for me". e only a small corner off of ated "I mainly wanted my t want chicken but they cut ded".			

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 12 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT			(X3) DATE SURVEY COMPLETED								
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COWIFE	EIED							
		HAL018035	B. WING		05/0	R 03/2018							
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
PIEDMONT VILLAGE AT NEWTON													
PIEDWON	PIEDMONT VILLAGE AT NEWTON NEWTON, NC 28658												
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE							
D 287	Continued From page	e 12	D 287										
	revealed: -They "don't put out k -They had not put kni long as she had been -She worked first shift breakfast and lunch n -She always went are asked if they needed Interview with a secon 8:40am revealed: -She had been workin November 2017They "never had put -She did not know the out at the tables for tr -Staff "always" asked "cutting their meats of Interview with the Cor revealed: -He had been working monthHe prepared the lund -The PCA's set the ta onlyHe did not know the out at the tablesThe PCA's assisted their food, as needed -Most of the meats the enough" that you wouthemIf provide with a list of the meat into pieces p -All the residents were	ves out at the table for "as a working there" (7 months). It and assisted with the neals. It and to the residents and assistance with their meal. It and PCA on 05/03/18 at ang at the facility since the residents. It and assisted residents with a speading jelly or butter". It is possible to the facility for about one on the facility since with a spoon and fork the residents with a spoon and fork the residents with a spoon and fork the residents with cutting											

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 13 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL018035	B. WING		05/0	3/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
PIEDMON	T VILLAGE AT NEWTON	1345 CHAF NEWTON, I	MAN LANE NC 28658			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 287	Continued From page 13		D 287			
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					

Division of Health Service Regulation

STATE FORM 6899 7CFH11 If continuation sheet 14 of 14