| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (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<br><br>An unannounced recertification and complaint investigation? survey was conducted 7/21/24 through 7/23/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #VTUR11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 7/21/24 through 7/23/24. Event ID# VTUR11. The following intakes were investigated NC00185586, NC00211905, and NC00216070.<br>2 of the 4 allegations resulted in deficiencies. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g) | F 580 | | |

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

Electronically Signed | 08/09/2024

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 1<br>(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to notify the physician of missed medication administration for 1 of 2 residents reviewed for notification (Resident #2).<br><br>The findings included:<br><br>Resident #2 was admitted to the facility 12/1/2021 with diagnoses including diabetes and hypertension. | F 580 | Past noncompliance: no plan of correction required. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 2 | F 580 | | |

Review of the physician orders for Resident #2 revealed an order dated 12/1/2022 for glipizide (an oral hypoglycemic) 10 milligrams (mg) daily for diabetes.

Review of Resident #2's medication administration record for December 2023 revealed the following dates were documented as not given and to see the nursing notes: 12/6/2023, 12/8/2023, 12/9/2023, 12/11/2023, and 12/14/2023.

Nursing notes were reviewed for Resident #2 and the following was documented:

12/6/2023 documented by Nurse #1: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: unavailable. The note did not document the physician had been notified the medication was not available.

12/8/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the physician had been notified the medication was not available.

12/9/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the physician had been notified the medication was not available.

12/11/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the physician had been notified the medication was not available.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 3 | F 580 | | |

12/14/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the physician had been notified the medication was not available.

Multiple attempts were made to contact Nurse #2 for interview, but Nurse #2 did not return the calls.

The former Director of Nursing (DON #1) was interviewed by phone on 7/22/2024 at 2:00 PM. DON #1 reported the facility had an automatic medication dispensing system that should have been stocked with routine medications for the residents and if the medication was not available, the physician should have been notified. The DON #1 reported she did not recall Resident #2 missing several doses of glipizide because the medication was not available and was not aware the physician was not notified.

Nurse #1 was interviewed by phone on 7/22/2024 at 3:48 PM. Nurse #1 reported she was no longer employed at the facility, but she had administered medications to Resident #2 in the past. Nurse #1 explained if the facility did not have medications in stock, she would have called the pharmacy and the physician. When reviewing documentation Nurse #1 completed on 12/6/2023, Nurse #1 reported she had no memory of the incident and did not know why she had not called the physician.

A phone interview was conducted with the facility physician (MD) on 7/23/2024 at 11:05 AM. The MD reported he had not been notified that glipizide 10 mg was not available for administration to Resident #2 and if he had been notified, he would have ordered a replacement

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 4 | F 580 | | |

medication. The MD explained that because Resident #2 was on other hypoglycemic medications, missing the 5 doses of the medication most likely had not harmed her, however, she should have received the medication, and he should have been notified she did not have 5 doses of the glipizide.

The Director of Nursing (DON #2) and Assistant Director of Nursing (ADON) were interviewed on 7/23/2024 at 12:44 pm. DON #2 reported she and the ADON did not start working for the facility until 2024 and they were not in the building when Resident #2 missed her medications in December 2023. DON #2 explained the staff were educated to call the physician if a medication was not available to administer and she did not know why Nurse #1 and Nurse #2 had not contacted the MD about Resident #2's glipizide.

The Regional Director of Clinical Services was interviewed on 7/23/2024 at 1:13 PM and she reported a mock survey was conducted in March 2024 and the survey discovered multiple issues with medication administration, including the physician was not notified for missed medications, and a plan of correction has been developed.

The facility provided a plan of correction dated 3/28/2024 for unavailable medications.

1. During Mock Survey on 3/26/2024 it was identified Physician/Responsible Party were not notified of missed medications.

2. To identify residents that have the potential to be affected the Director of Nursing/Designee

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 5 | F 580 | | |

immediately reviewed 100% electronic medication administration records for the past six months to ensure all residents medications were administered as ordered. 100% of residents affected with the documentation of medications unavailable during different months during this review time. Responsible party/Guardians notified of findings. Medical Provider notified and reviewed findings and agrees no significant medication errors. A Quality Assurance Performance Improvement (QAPI) meeting was conducted on 3/27/2024 to discuss findings, develop the plan of correction, and initiate monitoring. A Root cause analysis determined the lack of notification of the Physician and Responsible Party were due to nursing staff not following the procedure to notify.

3. To prevent this from happening again on 3/28/2024, the Director of Nursing/Designee completed education with 100% of Licensed Nursing Staff, Medication Aides and Current Agency Staff on the process of notification to the DON/Nurse Manager if any issues with obtaining medications, Notifying the Responsible Party if applicable, Notifying the Physician if unable to obtain the prescribed medication and request an interchange if available in the automated medication dispensing system. Licensed Nurses and Medication Aides educated on documentation and instructed "not to use medication unavailable" until all the above has been exhausted and Physician has given an order to hold until medication is available.

Newly hired Licensed Nursing Staff to be educated during Orientation. Agency nursing to be educated before assigned shift on Medication Administration Guidelines.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 6<br><br>4. To Monitor and Maintain Ongoing Compliance the facility will do the following:<br>The DON/Designee will audit the medication administration records 5x's a week for 12 weeks to ensure all medications guidelines are followed and in compliance and to ensure medical provider notified if any medication availability issues are identified.<br><br>The Administrator will report the results of the audits to the QAPI committee for review and recommendations for a minimum of three months.<br><br>Date of Compliance: 03/29/2024.<br><br>The facility date of compliance of 3/29/2024 was validated on 7/23/2024 by review of the education provided to nursing staff and medication aides, reviewing audit forms, reviewing medication administration records and nursing notes, review of the QAPI meeting notes, and interviews with nursing staff, Physician, Director of Nursing, and Assistant Director of Nursing. | F 580 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by: | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 7 | F 689 | Past noncompliance: no plan of correction required. | |

Based on record review, observations, staff, and physician interviews, the facility failed to provide care in a safe manner when a resident fell out of bed during incontinence care for 1 of 3 residents reviewed for accidents (Resident #12). Nursing assistant (NA) #1 rolled Resident #12 away from her during incontinence care and Resident #12 rolled out of bed. Resident #12 sustained a fractured tibia and fibula (bones below the right knee). Resident #12 required a 2-day hospitalization for the fracture and returned to the facility with a leg brace in place.

The findings included:

Resident #12 was admitted to the facility 11/24/2023 with diagnoses to include heart failure, kidney disease, lung disease, and diabetes.

The annual Minimum Data Set (MDS) assessment dated 11/16/2023 assessed Resident #12 to be cognitively intact. The MDS documented Resident #12 had no limits to her range of motion in her upper and lower body and required 1-person substantial assistance with bed mobility. The MDS documented Resident #12 required 2-person total assistance to transfer from her bed to a chair with the use of a mechanical lift.

Review of the care plan for Resident #12 (no date) included an intervention for 1 person assistance for bed mobility.

A nursing note dated 3/19/2024 at 4:27 PM written by Nurse #2 documented a fall on 3/19/2024 at 3:00 PM where Resident #12 was being provided incontinence care in the bed by

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 8 | F 689 | | |

Nursing Assistant (NA) #1. The note described Resident #12 rolling over in the bed and her legs slipped off the side of the bed causing her to slide to the floor and land on her knees. The note documented that Resident #12 reported pain below her right knee and her pain was rated "4" (on a 1-10 scale where 0= no pain; 10= severe pain). The note documented Resident #12 was administered over-the-counter pain medication and it was effective.

Resident #12 was interviewed on 7/23/2024 at 12:00 PM and she reported she did not recall the details of the fall on 3/19/2024. Resident #12 reported 2 staff members assisted her with bed mobility since the fall, and she was doing "just fine" since the fall. Resident #12 explained her pain level was controlled by medication, and she was wearing the leg brace.

NA #1 was interviewed on 7/23/2024 at 10:22 AM. NA #1 explained she was assigned to Resident #12 on 3/19/2024 and had been assisting her with incontinence care, when Resident #12 slipped off the bed and landed on the floor. NA #1 reported she had provided care to Resident #12 in the past and Resident #12 required only one staff member assistance at that time. NA #1 explained Resident #12 used the grab bars to pull herself over on her side. Regarding the incident on 3/19/2024, NA #1 reported she was on the left side of the bed and had helped Resident #12 to turn away from her on her right side for incontinence care. NA #1 described tucking a sheet under Resident #12's right hip and Resident #12 said, "Oh, I'll turn over more." Resident #12 leaned further to the right, when her legs slipped off the mattress and she slid to the floor. NA #1 explained because of the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 9 | F 689 | | |

weight of Resident #12's legs, the resident was unable to stop them from slipping off the mattress. NA #1 revealed she yelled for help and Nurse #2 and NA #2 arrived within a minute. NA #1 reported Resident #12 was on her knees at the side of the bed and was holding onto the upper grab rail and Resident #12 reported her right knee hurt. NA #1 explained that prior to this incident, Resident #12 had no problems rolling over in bed for care, but on 3/19/2024, her legs slipped off the mattress and this caused her to fall.

An interview was conducted with NA #2 on 7/23/2024 at 9:53 AM. NA #2 reported she was not assigned to Resident #12 on 3/19/2024, but she assisted NA #1 and the nurse to get Resident #12 off the floor by a mechanical lift after the fall. NA #2 reported prior to the fall, Resident #12 required 1 person assistance with bed mobility, but after the accident, 2 people always assisted her.

A phone interview was conducted with Nurse #2 on 7/23/2024 at 10:55 AM. Nurse #2 recalled the incident on 3/19/2024 when Resident #12 slid out of the bed during incontinence care. Nurse #2 described she was right outside of Resident #12's room when she heard NA #1 calling out for help and when she went in the room, found Resident #12 on the right side of the bed, by the window, on her knees and holding onto the bed rail. Nurse #2 reported Resident #12 expressed knee pain and she was given pain medication. Nurse #2 concluded by explaining she had called the physician, and he ordered an x-ray of Resident #12's right leg.

The physician was interviewed by phone on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 10 | F 689 | | |

7/23/2024 at 11:05 AM and he reported he was notified of the incident on 3/19/2024. The physician noted that while Resident #12 had a fractured tibia, she could have been hurt much worse.

X-ray results dated 3/19/2024 determined there was a proximal tibia and fibula fractures of the right leg just below the knee.

A nursing note dated 3/19/2024 at 11:52 PM documented Resident #12 was sent to the hospital emergency room for evaluation.

Hospital discharge orders dated 3/21/2024 documented Resident #12 had a traumatic closed displaced fracture of the proximal end of the right tibia (bone below the knee). Orders included no weightbearing on the right leg and Resident #12 was to wear a knee immobilizer until she followed up with the orthopedic surgeon.

The most recent Quarterly MDS assessment dated 5/23/2024 assessed Resident #12 to be cognitively intact. The MDS documented Resident #12 had range of motion impairment on both sides of her upper and lower body, and she required 2-person total assistance for bed mobility and required 2-person total assistance with a mechanical lift from bed to chair.

The facility provided a plan of correction dated 3/21/2024 for accidents.

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

On 3/19/2023 Resident #12 was in bed receiving

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 11 | F 689 | | |

incontinence care with the assist of NA #1. She rolled over to her right side and her feet slid out of bed. She was holding on to the grab bar and was unable to stop her feet from sliding. She landed on her knees. Upon assessment from the (former) Director of Nursing (DON #1), Resident #12 was noted to have bruising below right knee and was complaining of pain. The physician (MD) was notified and gave an order to obtain an x-ray of the right knee and leg. The knee and leg x-ray obtained and resulted on 3/19/2024 and was positive for a tibia fibula fracture. Resident #12 was sent to the hospital emergency department for evaluation and treatment on 3/19/2024.

A head-to-toe assessment was completed on Resident #12 by Director of Nursing (DON #1).

Education was provided to NA #1 regarding correct bed mobility and to roll a resident towards staff to prevent from rolling off the bed by the Assistant Director of Nursing (ADON) on 3/19/2024.

A pain assessment was completed by Nurse #1 on Resident #12 at 3:20 PM, and she received pain medication that was effective.

A fall assessment was completed by the ADON on 3/19/2024.

The MD was made aware of the incident by Nurse #1 on 3/19/2024 at 3:32 PM.

An X-ray was obtained on 3/19/2024, and the results received; Resident #12 was transferred to the hospital for evaluation and treatment on 3/19/2024 at 11:52 PM.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 12 | F 689 | | |

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.

Identified residents with like care concerns and performed bed mobility evaluation on all residents, which was completed by 3/20/2024 by the ADON and DON #1.

An ad-hoc Quality Assurance Performance Improvement (QAPI) meeting was held on 3/20/2024 to discuss the incident, the corrective action plan, and to begin monitoring.
Address how the facility will identify other residents having the potential to be affected by the same deficient.

Education to the NA staff related to bed mobility provided by the ADON starting 3/20/24 with direction for checking the Kardex for resident care needs and reporting any care changes. This education will be presented to new hire nurses and NAs by the ADON.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The DON/designee will complete an observation of care for 3 residents weekly for 4 weeks, then monthly for 2 months to ensure that residents that require assistance of 2 people are cared for appropriately per the care plan. Results will be taken to QAPI for review and revision as needed.
To monitor and maintain ongoing compliance, the DON/designee will audit point of care documentation (NA documentation of the amount of assistance a resident requires) 5 times a week for 8 weeks to ensure documentation is accurate

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 13<br>for newly identified at risk residents, including new admissions and high fall risk. New fall risks and new admissions will be discussed daily during the morning meeting. Documentation will be compared to fall risk assessments and bed mobility assessments. Results will be taken to QAPI for review and revision as needed.<br><br>The facility date of compliance: 3/21/2024<br><br>The facility date of compliance of 3/21/2024 was validated on 7/23/2024 by review of the education provided to nursing staff, reviewing audit forms, observation of bed mobility, review of the QAPI meeting notes, and interviews with nursing staff, physician, Director of Nursing, and Assistant Director of Nursing. During an interview with the Director of Nursing and Assistant Director of Nursing on 7/23/2024, they reported they were on the floor assisting staff with residents and provided hands on care, as well as oversight and observation during resident care to monitor for compliance. The Director of Nursing explained they monitored all residents. Incontinence care was observed on 7/21/2024 at 10:34 AM. Two staff members assisted Resident #12 with bed mobility and incontinence care. | F 689 | | |
| F 755 SS=E | Pharmacy Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. | F 755 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 14<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, and staff interviews, the facility failed to provide routine medications for 1 of 3 residents reviewed for medication administration (Resident #2).<br><br>The findings included:<br><br>Resident #2 was admitted to the facility 12/1/2021 with diagnoses including diabetes and hypertension. The most recent quarterly Minimum Data Set assessment assessed Resident #2 to be moderately cognitively impaired.<br><br>Review of the physician orders for Resident #2 | F 755 | Past noncompliance: no plan of correction required. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 15 | F 755 | | |

revealed an order dated 12/1/2022 for glipizide (an oral hypoglycemic) 10 milligrams (mg) daily for diabetes.

Additionally, physician orders for Resident #2 included the following hypoglycemic medications:
" Victoza 1.2 mg subcutaneous daily for diabetes ordered 11/11/2023
" Metformin 1000 mg orally twice daily for diabetes ordered 12/1/2022
" Sliding scale insulin as needed 3 times per day ordered 11/11/2023: give 2 units of insulin for blood sugars 200-250; give 4 units of insulin for blood sugars 251-200; give 6 units of insulin for blood sugars 301-350; give 8 units of insulin for blood sugars 351-400; give 10 units of insulin for blood sugars 401-450; give 14 units of insulin for blood sugars greater than 451 and call the physician.

Review of the medication administration record for December 2023 revealed the following dates glipizide 10 mg was documented as not given and to see the nursing notes: 12/6/2023, 12/8/2023, 12/9/2023, 12/11/2023, and 12/14/2023.

Nursing notes were reviewed for Resident #2 and the following was documented:
12/6/2023 documented by Nurse #1: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: unavailable. The note did not document the pharmacy had been contacted for refills.

12/8/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the pharmacy had been contacted for refills.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 16 | F 755 | | |

12/9/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the pharmacy had been contacted for refills.

12/11/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the pharmacy had been contacted for refills.

12/14/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the pharmacy had been contacted for refills.

Blood glucose results for Resident #2 were reviewed with the following results: (normal results from 70-120)
" 12/6/2023: 5:36 AM 423 10 units of sliding scale insulin given
" 12/6/2023: 12:19 PM 423 10 units of sliding scale insulin given
" 12/6/2023: 4:35 PM 281 4 units of sliding scale insulin given
" 12/8/2023: 6:09 AM 231 2 units of sliding scale insulin given
" 12/8/2023 11:16 AM 254 4 units of sliding scale insulin given
" 12/8/2023 5:03 PM 225 2 units of sliding scale insulin given
" 12/9/202: 7:01 AM 211 2 units of sliding scale insulin given
" 12/9/2023: 10:37 AM 255 4 units of sliding scale insulin given
" 12/9/2023: 3:56 PM 236 2 units of sliding

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 17 | F 755 | | |

scale insulin given
" 12/11/2023: 5:42 AM 165 no sliding scale insulin given
" 12/11/2023: 11:16 AM 253 4 units of sliding scale insulin given
" 12/11/2023: 4:36 PM 163 no sliding scale insulin given
" 12/14/2023: 3:56 PM 235 2 units of sliding scale insulin given

A pharmacy report of medication orders for Resident #2 in December 2023 documented glipizide 10 mg had been delivered on 12/18/2023.

Multiple attempts were made to contact Nurse #2 for interview, but Nurse #2 did not return the calls.

The former Director of Nursing (DON #1) was interviewed by phone on 7/22/2024 at 2:00 PM. DON #1 reported the facility had an automatic medication dispensing system that should have been stocked with routine medications for the residents. DON #1 explained staff nurses were instructed to look in the automatic medication dispensing system, then call the pharmacy and ask for the medication to be sent to the facility. DON #1 reported she did not recall Resident #2 missing several doses of glipizide because the medication was not available.

Nurse #1 was interviewed by phone on 7/22/2024 at 3:48 PM. Nurse #1 reported she was no longer employed at the facility, but she had administered medications to Resident #2 in the past. Nurse #1 explained if the facility did not have medications in stock, she would have called the pharmacy and the physician. When reviewing documentation Nurse #1 completed on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 18 | F 755 | | |

12/6/2023, Nurse #1 reported she had no memory of the incident and did not know why she had not called the pharmacy.

A phone interview was conducted with the facility physician (MD) on 7/23/2024 at 11:05 AM. The MD explained that because Resident #2 was on other hypoglycemic medications, missing the 5 doses of the medication most likely had not harmed her, however, she should have received the medication, and the pharmacy should have been notified the medication was not available.

A Pharmacist was interviewed by phone on 7/23/2024 at 11:31 AM. The Pharmacist explained that the facility was using an automated refill system for routine medications that required completion of a form every month for the refills to be completed. The Pharmacist explained the automated refill process would not be completed if the form was incomplete, and the pharmacy records indicated the refill request for October and November 2023 were not completed and the refills were cancelled. The Pharmacist reported the automatic medication dispensing system had glipizide available as a stock medication and the facility had refilled the automatic medication dispensing system with 10 tablets of glipizide 10 mg on 12/10/2023, but they had not taken any out of the automatic medication dispensing system. The Pharmacist revealed no calls were documented from the facility from 12/6/2023 to 12/14/2023 requesting a refill of glipizide for Resident #2, and no medications were removed from the automatic medication dispensing system for her in December 2023.

The Director of Nursing (DON #2) and Assistant Director of Nursing (ADON) were interviewed on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 19 | F 755 | | |

7/23/2024 at 12:44 pm. DON #2 reported she and the ADON did not start working for the facility until 2024 and they were not in the building when Resident #2 missed her medications in December 2023. DON #2 explained the ADON was completing the automated refill requests for the facility, so no refills were omitted. The ADON reported a daily report of missed medications was reviewed every morning to ensure that all residents were receiving their medications as the physician ordered.
The Regional Director of Clinical Services was interviewed on 7/23/2024 at 1:13 PM and she reported a mock survey was conducted in March 2024 and the survey discovered multiple issues with medication administration, including the pharmacy was not being contacted for medications that were not in-house or stocked in the automatic medication dispensing system and a plan of correction has been developed.

The facility provided a plan of correction dated 3/28/2024 for unavailable medications.

1. During Mock Survey on 3/26/2024 multiple documentations of medication unavailable in resident electronic medical records were identified.

2. To identify residents that have the potential to be affected the Director of Nursing/Designee immediately reviewed 100% electronic medication administration records for the past six months to ensure all residents medications were administered as ordered. 100% of residents affected with the documentation of medications unavailable during different months during this review time. Provider, Responsible party/Guardians (RP) were notified of findings

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 20 | F 755 | | |

and completed by 3/29/2024. A Quality Assurance Performance Improvement (QAPI) meeting was conducted on 3/27/2024 to discuss findings, develop the plan of correction, and initiate monitoring. A Root cause analysis determined missed medications were due to nursing staff not following the procedure to obtain medications that were not in the medication cart, the medication storage room, or in the automated medication dispensing system.

3. To prevent this from happening again, on 3/27/2024, the Director of Nursing/Designee completed education with 100% of Licensed Nursing Staff and Current Agency Staff on the process of obtaining and administering medications .The education is inclusive of the process for ordering medication when supply is low, checking the medication storage room for over stock medications, using the automated medication dispensing system, to identify if medication is available, Notifying the pharmacy for STAT delivery to the facility, Notification to the DON/Nurse Manager if any issues with obtaining medications, Notifying the RP if applicable, Notifying the Provider if unable to obtain the prescribed medication and request an interchange if available in the automated medication dispensing system. Licensed Nurses and Medication Aides were educated on documentation and instructed not to use "medication unavailable" until all the above has been exhausted and Provider has given an order to hold until medication is available.

Newly hired Licensed Nursing Staff to be educated during Orientation. Agency nursing to be educated before assigned shift on Medication Administration Guidelines.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 21<br><br>4. To Monitor and Maintain Ongoing Compliance the facility will do the following:<br>The DON/Designee will audit the medication administration records 5x's a week for 12 weeks to ensure all medications guidelines are followed and in compliance.<br><br>The Administrator will report the results of the audits to the QAPI committee for review and recommendations for a minimum of three months.<br>Date of Compliance: 03/29/2024.<br><br>The facility date of compliance of 3/29/2024 was validated on 7/23/2024 by observation of medication administration, review of the education provided to nursing staff, reviewing audit forms, reviewing medication administration records, nursing notes, review of the QAPI meeting notes, and interviews with nursing staff, Physician, Director of Nursing, and Assistant Director of Nursing. A medication administration observation was conducted 7/22/2024 and 7/23/2024. The facility had 0 errors out of 25 opportunities. | F 755 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control | F 880 | | 7/25/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 22 | F 880 | | |

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;
(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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 23<br>contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff interviews, the facility failed to handle soiled linens in a manner to prevent the spread of infection for 1 of 1 laundry room observation.<br><br>The findings included:<br><br>The facility policy Transmission-based Precautions and Isolation Policy dated 1/2014 with a revision date of 4/15/2024 read, in part: "Handle resident care ...laundry ... with standard precautions ..."<br><br>The facility laundry room was observed on 7/23/2024 at 12:05 PM. The Laundry Aide #1 was interviewed at the time of the observation. The soiled linen area was observed, and no personal protective equipment (PPE) was in the room. When asked to demonstrate moving soiled linen from the soiled linen bin, the Laundry Aide #1 demonstrated removing the soiled linen | F 880 | 1- Identified Laundry Staff not using proper PPE when handling Soiled Linens. Director of Nursing/Designee immediately educated the affected employee as evidenced by the education signature sheet. Completed on 7/23/24.<br>2- All residents have the potential to be affected by this practice. All residents assessed for any signs/symptoms of infection. No negative findings, as evidenced by the facility census check off sheet.<br>Additionally, proper PPE immediately stocked in laundry room for immediate use by all housekeeping- laundry staff as evidenced by the picture of the PPE available.<br>3- To prevent a reoccurrence, the Administrator and DON educated 100% staff on proper procedures for handling contaminated linens and the use of water | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345140 | A. BUILDING _____ B. WING _____ | C 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT HEALTH & REHAB CENTER | 610 WEST FISHER STREET SALISBURY, NC 28145 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 24<br>from a tied plastic bag and placed the soiled linen in the washing machine. Laundry Aide #1 reported she did not apply PPE when moving the soiled linen from the plastic bags into the washing machine and she did not have PPE in the laundry room.<br><br>The Infection Control Nurse was interviewed by phone on 7/23/2024 at 12:33 PM. The Infection Control Nurse reported Laundry Aide #1 should be using PPE to move soiled linen from the plastic bags into the washing machine. The Infection Control Nurse explained she had provided training to Laundry Aide #1 including the use of PPE for soiled linens and the Infection Control Nurse did not know why the Laundry Aide #1 was not using the PPE.<br><br>The Director of Nursing (DON) #2 was interviewed on 7/23/2024 at 12:41 PM and she reported she was not aware Laundry Aide #1 was not using PPE when moving soiled linens from the soiled linen bin to the washing machine. DON #2 explained she expected Laundry Aide #1 to use PPE to prevent the spread of infection when in contact with any soiled laundry.<br><br>The Administrator was interviewed on 7/23/2024 at 1:13 PM and he reported Laundry Aide #1 had started to work at the facility about 1 month prior and she had received training on using PPE with soiled linen and he did not know why she was not using PPE. | F 880 | soluble bags to ensure compliance with infections controls standards. This is evidenced by the staff education sheet and sign in form. This same education will be used with new agency staff and also all new hires during on-boarding orientation process.<br>4- The Administrator/Designee will observe the handling/laundering process 5xs/week for 12 weeks to assure infection control compliance as evidenced by the daily audit sheets.<br>Further, an AD-HOC QAPI meeting was held to address the plan of correction. This was completed on 07/24/2024 as evidenced by the QAPI signature form. The results of the audits will be reviewed monthly in the facility QAPI meeting for a minimum of three months to ensure compliance. The QAPI committee will review and advise necessary recommendations or changes as evidenced by the monthly QAPI signature sheet.<br><br>DOC: 07/25/2024 | |