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 _____	07/25/2018

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 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to have an Emergency Preparedness (EP) Plan. The EP plan did not include the facility's resident population, a system to track the location of the staff on duty and sheltered residents and the facility did not have the declared waiver by the Secretary. The communication plan did not address how the facility would share the Emergency Plan with resident's families or representatives. The facility also failed to have a training and testing program.	E 001	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.¿	7/27/18

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

Electronically Signed | 08/17/2018

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 _____	07/25/2018

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 001	Continued From page 1 Findings included: 1A. A review of the facility's EP plan did not address the resident population within the facility as well as the residents who needed special care such as oxygen and immobility. The plan did not address the type of services the facility can provide to the residents in an emergency. B. A further review of the EP plan revealed the facility did not have a system in place to track on duty staff and sheltered residents staying in the facility during an emergency C. The EP plan also did not contain the Declared Waiver by the Secretary discussing the facility's role for the provision of care at an alternate care site that had been identified by emergency management officials. D. The EP manual revealed the communication plan did not have any documentation as to how it would share the emergency plan information with the facilities residents, family members and/or representatives. E. A further review of the EP manual revealed there was no training program or testing requirements documented in the plan. An interview with the Administrator occurred on 7-25-18 at 5:00pm. The Administrator stated she believed she had the information but was unable to locate any of the information that was not found in the review of the facility's EP plan by the survey team. She also stated she had attended an EP table top discussion but was unable to say when or provide documentation of the training.	E 001	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: E001 It is the intent of this facility to comply with all applicable Federal, State and local emergency preparedness requirements. Further, it is the intent of Piedmont Crossing to establish and maintain a comprehensive emergency preparedness program that includes all required elements. 1) The plan of correcting the specific deficiency. A Root Cause Analysis (RCA) was utilized on August 14, 2018 to evaluate our processes to determine a root cause for the deficiency cited.¿ The RCA verified that while all elements required for our Emergency Preparedness Program were in place, the elements were divided into two separate notebooks and not placed into one notebook that conformed to the	

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 _____	07/25/2018

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 001	Continued From page 2 The Administrator stated she expected the EP manual to be complete and correct.	E 001	elements of the surveyor review form presented to the Nursing Home Administrator on July 23, 2018. Facility Assessment Emergency Preparedness The Facility Assessment Notebook included our resident population, residents with special care needs and the type of services that we can provide in an emergency. It also included our Shelter in Place procedures to include: where to shelter residents and how we would track and care for residents, families and visitors while Sheltering in Place. Also contained in the Facility Assessment Notebook was our training programs, including the Table Top exercise attended by the Nursing Home Administrator, Social Work Director and Environmental Director on October 5, 2017. This table top was hosted and led by our Triad Healthcare Preparedness Coalition. Also included in the Facility Assessment Notebook was information regarding an actual event that occurred at Piedmont Crossing on November 10, 2017 that included participation of our staff, local police department, investigators and the Special Weapons and Tactics □ SWAT team. The Emergency Preparedness Notebook contained agreements with alternate sites and with our sister PACE program Director for transportation of our residents to that site. Included are the types of residents we can care for at Piedmont	

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 _____	07/25/2018

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 001	Continued From page 3	E 001	Crossing as an evacuation site and how we would care for our residents at the alternate site Abernethy Laurels. Also included with the agreements is a policy regarding information regarding the Declared Waiver by the Secretary. In the Emergency Preparedness Notebook was the communication plan including how we would share information with residents, family members and/or representatives These notebooks were divided in this manner so that in the event of an Emergency, our staff could easily find telephone numbers and resources quickly without the need to filter through hundreds of pages. 2) The procedure for implementing the plan of correction for the specific deficiency On July 27, 2018, the Nursing Home Administrator compiled from both notebooks all elements required in this regulation. The Nursing Home Administrator then placed all elements into one notebook, ensuring that each element was separated accordingly to conform to the elements contained in the surveyor review form. This notebook will be utilized for annual review and updates as needed.	

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 _____	07/25/2018

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 001	Continued From page 4	E 001	3) The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. These corrective measures will be monitored by the Nursing Home Administrator with oversight by the Executive Director 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 Nursing Home Administrator 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 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		8/15/18

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 _____	07/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 5 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and observation the facility failed to maintain walls and ceilings, window screens, electrical outlets and window ledges for 6 of 12 resident rooms reviewed for a safe, clean, comfortable	F 584	Prefix Tag: F584 It is the intent of this facility to provide all of our residents with the right to a safe, clean, comfortable and homelike environment, including but not limited to	

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 _____	07/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 and homelike environment. (Rooms 306, 501, 504, 506, 508 and 510) Findings included: 1. During an observation of room 306 on 7-25-18 at 1:10pm the wall behind the bed was noted to have the paint chipped off exposing the plaster as well as a hole next to the wall electrical outlet allowing the electrical outlet to be loose. The resident stated he was unaware that was an issue and did not know how or when it happened. The maintenance man was interviewed on 7-25-18 at 2:53pm who stated the padding on the back of the beds headboard was removed from behind the bed which allowed the headboard to hit against the wall when the bed was moved, but he was unaware of the damage to the wall. An interview with the Administrator occurred on 7-25-18 at 4:20pm who stated she expected the facility to have a clean, orderly and safe environment for the residents. She also stated she expected staff to use their maintenance repair logs to request repairs when they see an issue in the facility that needs to be fixed in the facility by the maintenance staff. A review of the maintenance repair logs from 5-26-18 to 7-25-18 revealed that there were no requests by staff for room 306 2. During an observation of room 501 on 7-25-18 at 1:12pm the popcorn ceiling was noted to be chipping exposing the plaster underneath approximately 10 feet long and 3 inches wide, the screen on the inside had dirt and cob webs and the window ledge was noted to have crumbs and dust. The resident was not interviewable.	F 584	receiving treatment and supports for daily living safely. 1) The plan of correcting the specific deficiency. A Root Cause Analysis (RCA) was utilized on August 14, 2018 to evaluate our processes to determine a root cause for the deficiency cited.¿Present were the Environmental Director, Maintenance Director, Director of Nursing and Nursing Home Administrator. The RCA verified that while Piedmont Crossing has processes in place to repair resident rooms, common areas and to ensure all of our resident□s environments are clean and safe, there existed a misunderstanding in the questions being posed by the State Surveyor and the answers being given by our Department Heads. Our Maintenance logs are utilized for repairs that are completed by our Maintenance Department. They are not utilized for repairs requiring outside Contractors. 2) The procedure for implementing the plan of correction for the specific deficiency On July 25, 2018, the Maintenance Department immediately replaced the cracked receptacle plate in room 306. On July 25, 2018, the Environmental Director inspected window ledges, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345310	A. BUILDING _____ B. WING _____	07/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7 An interview with the maintenance director on 7-25-18 at 2:55pm revealed he was unaware of the issues with the screen or window ledge because there had not been a request entered into the computer system but that he had been aware of the popcorn ceiling chipping. He stated he had been trying to repair the worst ceilings first. An interview with the Administrator occurred on 7-25-18 at 4:20pm who stated she expected the facility to have a clean, orderly and safe environment for the residents. She also stated she expected staff to use their maintenance repair logs to request repairs when they see an issue that needs to be fixed in the facility by the maintenance staff. A review of the maintenance repair logs from 5-26-18 to 7-25-18 revealed that there were no requests by staff for room 501. 3. During an observation of room 504 on 7-25-18 at 1:15pm the popcorn ceiling was noted to be peeling off and chipped approximately 3 feet long and 3 feet wide exposing the plaster underneath. Also, the room's inside window screen was dirty and had cob webs. The residents in the room were not interviewable. The maintenance director was interviewed on 7-25-18 at 2:57pm who stated he was aware of the popcorn ceiling being chipped and that he was addressing the issue but had not been unaware of the screen being dirty because he had not been informed by staff through the computer system. An interview with the Administrator occurred on	F 584	found no dirt or debris On July 26, 2018, the Maintenance Supervisor had the window screens in room 501 and in room 504 replaced On August 13, 2018, the Environmental Director added inspection of screens to the items to be cleaned during weekly deep cleaning of rooms. On August 13, 2018, the Nursing Home Administrator and the Director of Nursing inspected all screens for dirt, cobwebs or disrepair. None were located. On August 15, 2018, the Environmental Director met with the Contractors present and asked them to make repairs to the wall in room 306. The repairs were completed on August 15, 2018. At some point in early 2018, we noted that the popcorn ceilings were beginning to chip. As rooms became available to relocate residents into, we began with the ceilings with the most extensive chipping. Residents were relocated into other rooms by direct care staff, all of their belongings were removed from the room and the popcorn ceilings were taken down by our contracted painter. The sheetrock was painted as was the entire room. This process takes anywhere from 7-14 days depending on the availability of contract staff and the availability of empty rooms to relocate resident into during the room repair. To date, we have repaired 14	

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 _____	07/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8 7-25-18 at 4:20pm who stated she expected the facility to have a clean, orderly and safe environment for the residents. She also stated she expected staff to use their maintenance repair logs to request repairs when they see an issue that needs to be fixed in the facility by the maintenance staff. A review of the maintenance repair logs from 5-26-18 to 7-25-18 revealed that there were no requests by staff for room 504. 4. During an observation of rooms 506, 508 and 510 on 7-25-18 at 1:20pm the popcorn ceiling was noted to be chipping off exposing the plaster underneath. The popcorn ceiling in room 506 was chipping off approximately 3 feet long by 3 feet wide by the bathroom door, the ceiling in 508 had approximately a 6-foot-long by 3 inches wide area chipping off and room 510's ceiling had an area approximately 3 feet long by 3 feet wide chipping off exposing the plaster underneath. The residents in the 3 rooms stated they had not noticed the issues with the ceiling. The maintenance director was interviewed on 7-25-18 at 3:05pm who stated he was aware of the problem with the popcorn ceilings and that he had been working on the worst ceilings first. An interview with the Administrator occurred on 7-25-18 at 4:20pm who stated she expected the facility to have a clean, orderly and safe environment for the residents. A review of the maintenance repair logs from 5-26-18 to 7-25-18 revealed that there were no requests by staff for room 506, 508 and 510.	F 584	rooms. We will continue this process until all rooms with chipping popcorn ceilings have been repaired. Our Housekeeping staff, Certified Nursing Assistants and Licensed Nurses will continue to report issues requiring repair by either Maintenance or contractors on a daily basis. Weekly, our Housekeeping Staff will continue to inspect our resident□s rooms during deep cleaning and report issues on the Room Ready checklist. This checklist is given to the Supervisors to ensure follow through. The Housekeeping staff and our C.N.A.s will continue to inspect and report any issues in the resident rooms during terminal cleaning following the discharge of a resident. They will continue to utilize the Room Ready Checklist to note their findings and this checklist will be given to the Supervisor to ensure follow through. The Environmental Director will continue weekly room rounds to ensure that all resident rooms and common areas utilized by residents are clean and debris-free. Findings will be placed on the Environmental Services QAPI Checklist and reported on during our quarterly QAPI meeting. The Maintenance Director will continue weekly room rounds to ensure that resident rooms and common areas utilized by residents are in good repair and safe for our residents. Findings will be placed on the Maintenance Director QAPI Checklist and reported on during our	

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 _____	07/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9	F 584	quarterly QAPI meeting. 3) The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. These corrective measures will be monitored by the Environmental Director and Maintenance Supervisor 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 Environmental Director and Maintenance Supervisor 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 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed	F 805		8/20/18

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 _____	07/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 10 to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to provide the proper food consistency for 6 of 6 pureed meals served to Resident #500, Resident #300, Resident #31, Resident #82, Resident #57, and Resident #74 in the 500-dining room. Findings included: Resident #500, Resident #300, Resident #31, Resident #82, Resident #57, and Resident #74 diet orders were reviewed and revealed they were all on a pureed diet at meals. Observation on 07/23/18 at 12:25 PM, 6 plates of pureed foods (pureed chicken, pureed carrots, and pureed broccoli) were served to Resident #500, Resident #300, Resident #31, Resident #82, Resident #57, and Resident #74 in a thin liquefied form mixing together on each plate. Observation with the Dietary Manager (DM) on 7/25/18 at 12:15 PM revealed 6 plates of pureed foods were served to Resident #500, Resident #300, Resident #31, Resident #82, Resident #57, and Resident #74 in the 500-dining room. The pureed foods (broccoli, mashed potatoes, and pureed spaghetti sauce) were again in a thin liquefied form mixing together on each plate. The DM did not intervene or obtain another tray for these residents. Resident #500, Resident #300, Resident #31, Resident #82, Resident #57, and Resident #74 were unable to answer questions appropriately when asked about their food.	F 805	Prefix Tag: F805 It is the intent of this facility to provide each resident with food prepared in a form designed to meet individual needs. 1) The plan of correcting the specific deficiency. A Root Cause Analysis (RCA) was utilized on August 6, 2018 to evaluate our processes to determine a root cause for the deficiency cited. Present during the Root Cause Analysis were: District Manager for Sodexo, the Registered Dietician and the Food Services Supervisor.¿ The RCA verified that there was a lack of consistent education with the dietary cooks responsible for the preparation of our pureed foods. Proper audits were not in place to ensure that the correct consistency of pureed foods were sent to our pantries for serving. 2) The procedure for implementing the plan of correction for the specific deficiency On 7/31/2018, our cooks were educated by the Registered Dietician and Interim Dietary Manager on the correct use of recipes for pureed foods and how to correct the consistency at production if the consistency is incorrect.	

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 _____	07/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 11 Cook #1 was interviewed on 7/25/18 at 1:28 PM who stated no water had been added to puree the foods. Continued interview with Cook #1 stated they (the facility) tried not to use food thickener for the pureed foods and add more of the actual food to make it thicker. Cook #1 stated the pureed foods should not be in a thin form that would allow the foods to mix together and if known, he would have corrected the thin form of the pureed foods. On 7/25/18 at 1:37 PM, the DM stated there had been past issues about the pureed foods consistency and today (referring lunch on 7/25/18) the consistency of the pureed meal was too thin. DM stated the cook in the kitchen should be following the recipe when making the pureed food. The Administrator was interviewed on 7/25/18 at 4:05 PM and stated she would expect the pureed foods to be the proper consistency and appealing.	F 805	On 8/1/2018 a Quality Assurance Tool was introduced to all dietary cooks by the Interim Dietary Manager. On 8/1/2018, daily audits of the consistency of the pureed foods during all three meals began by the Registered Dietician, Interim Dietary Manager, Nursing Home Administrator and Nursing Supervisors. These audit findings are placed on the Puree modification-production audit and will continue daily until 8/24/2018. Then, the Registered Dietician and Food Services Supervisor will continue ongoing audits three times a week to include at least one breakfast, one lunch and one dinner meal. On 8/1/2018, the Interim Dietary Manager, the Registered Dietician and the Food Services Supervisor began providing education to cooks, chefs, servers and C.N.A.s to include the following: Recipes How to make purees How to correct consistency at production How the pureed foods should look (including photos) to servers and C.N.A.s Correct serving utensils and dishes to ensure correct shape of pureed foods Instruction given to servers and C.N.A.s on who to call if standards are not met This training will include the PurForm training modules (including videos) and should ensure both the correct taste and consistency. Training will be completed by 8/20/2018.	

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 _____	07/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 12	F 805	3) The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. These corrective measures will be monitored by the Dietary Manager 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 Dietary Manager 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.	