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 _____	08/21/2014

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 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to update care plan problems, goals and approaches for one of seventeen sampled residents with care plans. Resident # 54. The findings included: 1. Resident #54 was admitted to the facility on 3/27/14 with diagnosis of heart failure, depression and seizure disorder. The Minimum Data Set (MDS) dated 6/19/14	F 280	Preparation and execution of this plan of correction in no way constitutes an admission of agreement by this facility of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare and Medicaid programs if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the	9/17/14

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

Electronically Signed | 09/12/2014

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 _____	08/21/2014

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 280	Continued From page 1 indicated Resident #54 was independent after set up for eating, had no chewing or swallowing problems and her current weight was 129 pounds. This MDS documented no significant weight loss during the assessment timeframe. The dietary note dated 7/29/14 addressed significant weight loss in the past 30 days of 5.5%. The registered dietician documented the following interventions for weight loss: " Will add MVI (multivitamin) daily and 30 ml (milliliters) med pass bid (twice a day). " The registered dietician indicated Resident #54 had weight fluctuations monthly and was on a diuretic for congestive heart failure. Review of the care plan that was updated on 7/30/14 included problems of at risk for weight loss related to chronic illness. The stated goal included Resident #54 would maintain a weight within 2 to 3 pounds of her current weight. Interventions included staff was to honor food preferences, monitor oral intake, monitor weights weekly and begin " every bite counts program at meals. " The every bite counts program consisted of fortified foods. The significant weight loss was not addressed, the goal was not changed and the new approaches were not added to the care plan. Interview with the Director of Nursing on 8/21/14 at 10:45 AM revealed the care plan was not updated due to being missed. She further explained she thought the resident's weight was stable.	F 280	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. F280: RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP How corrective action will be accomplished for those residents found to have been affected by deficient practice Resident affected had order written to re-start Med Pass and discontinue multivitamin on 8/21/14. Intervention was added to Care Plan and goal was re-stated on 8/21/14. How corrective action will be accomplished for those residents having potential to be affected by deficient practice RD provided list of residents that triggered for weight loss at 30, 90 and 180 days. All residents were evaluated for proper interventions and goals on care plans on 8/21/2014. What mesures will be put into place or	

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 _____	08/21/2014

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 280	Continued From page 2	F 280	systemic changes made to ensure that the deficient practice does not occur again All residents requiring a Care Plan for weight loss will have appropriate goals. Goal will state that the resident's weight will be maintained or will not exceed greater than a 5% loss in 30 days. All residnets triggering for weight loss will be monitored weekly, or more frquently if indicated. Residents will be discussed in weekly weight meeting including RD, DON and Nurse Supervisors. Interventions will be modified and orders written as needed and Care Plans will be updated. Any new interventions will be communicated via order to nurses and via Kardex/CNA worksheet. How facility will monitor effectiveness of plan ensuring that correction is achieved and maintained. A QAPI check list of residents discussed in weekly weight meeting will be maintained by RD. Check list will include: weight, intervention, order written if needed, Care Plan updated, CNA kardex/worksheet updated. QUAPI checklist will be shared at monthly QAPI committee meeting. Date when corrective action will be completed. 9/15/2014 F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELLBEING	

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 _____	08/21/2014

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 280	Continued From page 3	F 280	How corrective action will be accomplished for those residents found to have been affected by deficient practice Water pitcher was removed from room and resident placed on thickened liquid list on 8/20/14 How corrective action will be accomplished for those residents having the potential to be affected by deficient practice A list of all residents on thickened liquids was obtained and DON assured that all residents with orders for thickened liquids were included on this list and the proper consistency of liquid was available in the residents' rooms. What measures will be put in place or systemic changes made to ensure that the deficient practice does not occur again All newly admitted residents with orders for thickened liquids will have a nursing to dietary communication form completed and given to the RD upon admission A sign indicating resident's liquid consistency will be placed in room over resident's bed by nurse receiving order. N=indicates nectar and H=indicates honey Any change in existing liquid consistencies will be communicated by therapy to nursing form with a copy given to the RD. RD will add resident's name to the thickened liquid list used by dietary	

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 _____	08/21/2014

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 280	Continued From page 4	F 280	when passing beverages. Nurse receiving the order will ensure that the proper liquids are placed at bedside and appropriate sign (N or H) is above bed. RD will update resident Kardex and CNA worksheet at the time the order is received. Nursing Supervisor will be responsible in the absence of RD. How facility will monitor effectiveness of plan to ensure that correction is achieved and maintained. An audit of all residents on thickened liquids will be completed weekly by First Shift Supervisors. Audit results will be reported to QAPI Committee monthly for three months and then quarterly for one year. Variation from orders will be brought to the attention of the DON and RD immediately. Education on POC will be completed by ADON by 9/17/14. Date when corrective action will be completed: 9/17/14 F-318 483.25 INCREASE/PREVENT DECREASE IN RANGE OF MOTION How corrective action will be accomplished for those residents found to have been affected by deficient practice Resident was screened by OT for appropriateness of splint use. Splint	

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 _____	08/21/2014

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 280	Continued From page 5	F 280	deemed appropriate on 8/20/14 Order written for Restorative Nursing to apply and remove splint to begin on 8/21/14. Resident Care Plan updated to include use of splint and splinting placed on Kardex and CNA worksheet to be performed by Restorative Nursing. How corrective action will be accomplished for those residents having the potential to be affected by deficient practice. List of all residents with orders for splints was obtained and DON ensured that these residents had Care Plans indicating splinting as intervention. What measures will be put in place or systemic changes made to ensure that the deficient practice does not occur again All residents requiring splints will be placed on Restorative Nursing caseload after Restorative Aides have been in-serviced by therapy on use of the splint. ADON will conduct weekly meeting with Restorative Aides to discuss status of each resident to focus on tolerance of splint, fitting of splint, and affects on ROM. Any changes noted will be up-dated on resident's Care Plan by ADON. If appropriate, changes will be made to Kardex and CNA worksheet. How facility will monitor effectiveness of plan ensuring that correction is achieved and maintained	

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 _____	08/21/2014

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 280	Continued From page 6	F 280	Minutes from weekly Restorative Nurse Aide meetings will be shared at monthly QAPI meeting for three months and then quarterly for one year. F325 483.25 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE How will corrective action be accomplished for those residents found to have been affected by deficient practic Resident affected had order written to re-start Med Pass and discontinue multivitamin on 8/21/14. Intervention was added to resident's Care Plan on 8/21/14. How corrective action will be accomplished for those residents having potential to be affected by deficient practice. RD provided residents that triggered for weight loss at 30,90 and 180 days. All residents evaluated for proper interventions and goals on Care Plan.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		9/17/14

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 _____	08/21/2014

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 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observations, the facility failed to ensure that nectar thickened liquids were available at bedside as ordered by physician for 1 of 2 sampled residents (Resident #34). Findings included: Resident #34 was readmitted to the facility on 8/12/14 with diagnosis of bronchial obstruction, bacterial pneumonia and dyphagia. Review of the Minimum Data Set (MDS) with assessment reference date of 8/19/14 indicated that Resident #34 was moderately cognitively impaired, required extensive assistance with Activity of Daily Living (ADL ' s) and required a mechanical altered diet. A speech-language pathology modified barium swallow study completed 8/11/14 prior to admission recommended mechanical soft diet with nectar thick liquids. The admission physician orders dated 8/12/14 revealed a diet order for a mechanical soft diet, no added salt and nectar thick liquids. Review of the 8/12/14 admission interim plan of care indicated a regular diet with regular liquids. During an observation on 8/20/14 at 11:40 AM revealed Resident #34 in room sitting in wheelchair with 2 containers of nectar thick lemon water, 1 container of nectar thick cranberry juice and a water picture full of thin ice water and straw on over bed table in reach for Resident #38.	F 309	F 309 483.25 Provide Care/Services For Highest Well Being It is the practice of this facility to ensure that residents receive liquids at correct consistency per MD/Practitioner order How corrective action will be accomplished for those residents found to have been affected by deficient practice Resident #34 had water pitcher removed from room and resident placed on thickened liquid list on 8/20 by RD How corrective action will be accomplished for those residents having potential to be affected by deficient practice List of all residents on thickened liquids obtained and ADON/DON assured that all residents were on thickened liquid list and that proper consistency of liquids was available in room on 8/20. What measures will be put into place or systemic changes initiated to ensure that the deficient practice does not occur again All newly admitted residents on thickened liquids will have a nursing to dietary communication form completed and given to the RD at time of admission A sign indicating resident's liquid consistency will be placed inside 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 _____	08/21/2014

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 309	Continued From page 8 During an interview with the dietary aide #1 on 8/20/14 at 11:45 AM revealed that she delivers ice water to the residents twice a day and she did not have Resident #38 on the list to indicate that she needed thickened liquids. An interview with the dietary aide #1 on 8/20/14 at 2:32 PM indicated that she has an updated list now. Resident #34 was not on the list for thickened liquids, but they have added her now. During an interview with nurse aide (NA) #1 at 2:50 PM on 8/20/14 revealed that resident needs are communicated to the NA ' s by the nurse ' s report and also by the household NA worksheets. The household worksheets list the diet assistance/precautions and diets for each resident. Review of the household NA worksheet dated 8/14/14 revealed no information provided for Resident #34 for diet assistance and diet precautions, those sections were blank. An observation of Resident #34 at 3:00 PM on 8/20/14 revealed Resident #34 up sitting in her wheelchair with a water picture of thin liquids and straw in reach. During an interview with the director of nurses on 8/20/14 at 3:45 PM revealed that her expectations are that residents on thickened liquids are communicated to dietary and they are place on a list for thickened liquids. Any changes to a resident ' s plan of care are updated in morning meeting and the information is place on the Kardex for NA ' s information. Residents on thickened liquids have a cooler placed in their	F 309	resident's room over their bed : N=nectar and H=honey by the nurse receiving the order. Any change in existing liquid consistencies by therapy will be communicated by therapy to nursing form with a copy being given to the RD to add to the thickened liquids list. Nurse receiving the order will then ensure that the proper liquids are in the room and that the correct sign is placed above the resident's bed. RD will be responsible for updating the resident's Kardex as well as the Household C.N.A. worksheet at the time the order is obtained. In the absence of the RD, the appropriate Nursing Supervisor will be responsible for the changes. How facility will monitor effectiveness of plan ensuring that correction is achieved and maintained Any variations from the physician's order will be brought to the DON and RD attention immediately. Education on POC steps will be completed with all shifts by ADON. These measures will be monitored by the RD with oversight by the Administrator through the Quality Assurance Process. The RD will report on the measures implemented to the QAPI Committee	

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 _____	08/21/2014

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 309	Continued From page 9 room with prethickened beverages.	F 309	which will monitor for effectiveness for monthly for 3 months and then quarterly times one year. The committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that the recommendations are acted upon in a timely manner.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide left resting hand splint according to physician orders and therapy recommendations for 1 of 1 resident (Resident #77) whose splint was not applied correctly and not applied. The findings included: Resident #77 was admitted to the facility on 9/02/13 with diagnoses that included Muscular disuse atrophy, difficulty walking, dysphasia and dementia without behavioral disturbance. The most recent Minimum Data Set Assessment (MDS) dated 6/12/14 indicated impairments of upper extremities and required extensive	F 318	F 318 - 483.25 Increase/Prevent Decrease In Range of Motion It is the policy of this facility to apply splints according to physician orders How corrective action will be accomplished for those residents found to have been affected by deficient practice. Resident #77 was screened by OT for appropriateness of splint in use. Splint deemed appropriate on 8/20. Order written for Restorative Nursing by DON to both apply and remove splint to begin on 8/21/14. Care plan updated to	9/17/14

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 _____	08/21/2014

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 318	Continued From page 10 assistance for activities of daily living. The MDS further indicated Resident #77 was severely cognitively impaired for daily decision making. Review of Resident #77 care plan dated 6/16/14 revealed a "problem" for potential for pain related to contractures. The goal stated resident will have pain controlled to tolerable level as evidenced by no nonverbal signs of paint noted times 90 days. The interventions did not indicate splint application. Review of Resident #77's physician orders revealed an order written 6/12/14 that said discontinue skilled occupational services; staff to apply splints to splinting program in place. Physician order written on 6/16/14 revealed, occupational therapy (OT) for left resting hand splint to be applied from at 6:00 am 6:30am until bed time. Review of Resident #77's Occupational Therapy Discharge Summary dated 6/16/14 stated, resident to increase her wearing tolerance to the left hand splint and left elbow splint for skin integrity and increased range of motion (ROM) and left upper extremity (LUE). Staff to be educated and independent with donning and doffing left hand splint and left elbow splint for patients left upper extremity (LUE). Patient to have 1st shift nursing assistant (NA) to donn (applied) and doff (remove) left hand splint independent for patients LUE to increase ROM. Patient to have 2nd shift NA to donn and doff left elbow splint independently for patient LUE skin integrity. Pictures to be made and placed in the appropriate locations for proper positing and for proper donning of LUE splints.	F 318	include use of splint by DON on 8/20. Splinting placed on Kardex and Household CNA worksheet by DON. How corrective action will be accomplished for those residents having potential to be affected by deficient practice List of residents requiring splints was obtained and DON ensured that each resident was on Restorative Nursing for splinting and that the Care Plan indicated splinting as an intervention on 8/20. What measures will be put into place or systemic changes initiated to ensure that the deficient practice does not occur again All residents requiring splints will be placed on Restorative Nursing after Restorative Aides have received education by therapy on use of splint. ADON will meet weekly with the Restorative Aides to discuss status of each resident to focus on tolerance of splint, fitting of splint, and affects on ROM Any changes will be reflected in the resident's Care Plan and updates made at the meeting as needed by the ADON Any information that needs to be communicated to the staff will be placed on the resident's Kardex and on the Household CNA worksheet by ADON How facility will monitor effectiveness of plan ensuring that correction is achieved and maintained.	

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 _____	08/21/2014

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 318	Continued From page 11 Review of Resident #77's treatments on medical administration record indicated an order date of 6/17/18 that stated left elbow splint to be on from bedtime to 6:30 and left resting hand splint on from 6:30 until bedtime. Observations on 8/18/14 at 12:46 pm revealed Resident #77 on the 200 hall dining area with left hand in resting hand splint. Resident #77's left hand was not observed to be resting on the resting hand splint. The palm portion of the resting hand splint was observed to be to the right of the resident's hand. Resident #77's fingers were observed to curled under (fingers to palm of hand). Observation of Resident #77 on 8/20/14 at 8:45 am revealed no splinting to left hand. Observation of Resident #77 on 8/20/14 at 10:24 am revealed no splinting to left hand. Interview with NA#2 on 8/20/14 at 10:55 am revealed she becomes aware of individual resident needs by a CNA work sheet that is located on individual facility neighborhoods. NA#2 indicated that she typically floats and requires the work sheet to identify if any changes have been made to resident care areas. Resident #77 had a visual aid attached to her closet detailing splint application. NA#2 indicated Resident #77's splints were to be applied on 2nd and 3rd shifts. Review of Resident #77's work revealed a column identifying splinting. Resident #77's NA work sheet identified no splinting. Observation of Resident #77's visual aid of splint	F 318	These measures will be monitored by the ADON with oversight by the Administrator through the QAPI process. The ADON will report on the measures implemented to the QAPI committee which will monitor for effectiveness monthly times 3 months and quarterly times one year. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that these recommendations are acted upon in a timely manner.	

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 _____	08/21/2014

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 318	Continued From page 12	F 318		

application attached to resident closet indicated 3rd shift puts on Left resting hand splint and 2nd shift take off the resting hand splint.

Interview with Nurse #1 on 8/20/14 at 11:06 am revealed Resident #77 was to wear a left resting hand splint that should be applied daily at 6am. Nurse #1 stated occupational therapy (OT) provides training and teach NA's how to apply splinting devices. Nurse #1 stated it was her responsibility to ensure NA's are applying resident splints correctly. While interviewing Nurse #1 an observation of Resident #77 was conducted. Nurse #1 revealed Resident #77 did not have on her required left hand resting splint. Nurse #1 took Resident #77 to her room to put on her required splinting device.

During an interview with the OT supervisor on 8/20/14 at 2:35 pm revealed Resident #77 splinting needs were broken up into 2 different shifts. The am shift was to apply the left resting hand splint and the evening shift were to apply the elbow splint. Resident #77 splinting should be applied daily. While interviewing OT supervisor an observation of Resident #77's splint application was conducted. The OT supervisor stated Resident #77's hand splint was incorrectly applied. The OT superior stated indicated she had provided the visual aids of correct splint application. The OT supervisor indicated it was her expectation that the residents ordered splinting be applied as ordered and correctly to prevent worsening of contractures or skin breakdown.

Interview with the Director of Nursing (DON) on 8/21/14 at 10:31 am revealed it was her expectation that residents who require splinting

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 _____	08/21/2014

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 318	Continued From page 13 be provided splinting as ordered. It was further the DON's expectation that splints for contracture prevention be applied correctly.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to implement a nutritional supplement as an intervention after significant weight loss was identified for one of four sampled residents for nutritional review. (Resident #54) The findings included: Resident #54 was admitted to the facility on 3/27/14 with diagnosis of heart failure, depression and seizure disorder. The Minimum Data Set (MDS) dated 6/19/14 indicated Resident #54 was independent after set up for eating, had no chewing or swallowing problems and her current weight was 129	F 325	F 325 - 483.25 Maintain Nutrition Status Unless Unavoidable It is the policy of this facility to provide nutritional supplements as ordered How corrective action will be accomplished for those residents found to have been affected b deficient practice Resident #54 had an order written to initiate Med Pass and discontinue MVI by DON on 8/21/14 Intervention was added to the Care Plan and goal was re-stated on 8/21 by DON How corrective action will be	9/17/14

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 _____	08/21/2014

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 325	Continued From page 14 pounds. This MDS documented no significant weight loss during the assessment timeframe. The dietary note dated 7/29/14 addressed significant weight loss in the past 30 days of 5.5%. The registered dietician documented the following interventions for weight loss: " Will add MVI (multivitamin) daily and 30 ml (milliliters) med pass bid (twice a day). " The registered dietician indicated Resident #54 had weight fluctuations monthly and was on a diuretic for congestive heart failure. Review of the care plan that was updated on 7/30/14 included problems of at risk for weight loss related to chronic illness. The stated goal included Resident #54 would maintain a weight within 2 to 3 pounds of her current weight. Interventions included staff was to honor food preferences, monitor oral intake, monitor weights weekly and begin " every bite counts program at meals. " The every bite counts program consisted of fortified foods. Review of a telephone order dated 7/30/14 indicated Resident #54 was to receive 30ml of med pass supplement bid and a MVI once a day. The order was written by the registered dietician and signed by the physician. Review of the August 2014 monthly physician orders revealed a diet order of No Added Salt. The med pass supplement and use of the daily multivitamin was not added to the monthly orders for August 2014. The order for Lasix was 20 milligrams every day and the dose had not been changed in the last six months. Observations on 8/20/14 at 9:20 AM revealed	F 325	accomplished for those residents having potential to be affected by deficient practice RD provided a list of residents that triggered for wt. loss at 30days, 90 days and 180 days on 8/21/14 All residents evaluated for proper interventions and goals on care plans by DON on 8/21 What measures will be put into place or systemic changes initiated to ensure that the deficient practice does not occur again All residents requiring a Care Plan for weight loss will have appropriate goals Goal will state that resident's weight will be maintained or will not exceed more than a 5% loss in 30 days All residents triggering for wt. loss will be monitored weekly or more often as indicated. Residents will be discussed weekly by RD, DON and Supervisor. Interventions will be changed as needed and care plans will be updated at that time. Any new interventions will be communicated via order to nurses and via Kardex/Household CNA Worksheet Any new orders written will be placed into computer during meeting to ensure carry through. RD will discuss intervention with resident or RP. Refusal of intervention by resident will be communicated via nurse's note, indicated on electronic MAR and via nursing 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 _____	08/21/2014

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 325	Continued From page 15 Resident #54 was seated in the dining room for breakfast. She ate independently and consumed 75% of the breakfast. Interview on 8/21/14 at 9:25 AM with medication aide #1 revealed Resident #54 did not have an order in the eMAR (electronic Medication Administration Record) for the med pass or the multivitamin. Interview with the Director of Nursing (DON) on 8/21/14 at 9:47 AM revealed Resident #54 did not like the med pass supplement. She explained the order was written after a weight meeting. Continued explanation included she thought it was discussed with the interdisciplinary team the med pass supplement would be discontinued. Interview with the Registered Dietician (RD) on 8/21/14 at 10:05 AM revealed the resident's weight was stable and she remembered the aides telling her the resident did not like the med pass. No explanation was provided regarding use of the med pass as an intervention for the weight loss. Interview with the DON on 8/21/14 at 10:10 AM revealed the resident did not like the med pass and an order to discontinue the med pass was not written. The resident was receiving fortified foods. Resident #54 had stable weights per the RD and the med pass should have been discontinued. Interview with resident #54 on 87/21/14 at 10:17 AM revealed she had received a supplement one time and she liked it. The resident further stated she would like to have more of it. Resident #54 recalled receiving the supplement " several weeks ago. "	F 325	dietary communication form. Refusal will also be communicated immediately to DON. POC will be educated to all shifts by ADON/Dietary Manager How facility will monitor effectiveness of plan ensuring that correction is achieved and maintained A list of residents discussed weekly will be maintained by the RD These measures will be monitored by the RD with oversight by the Administrator through the QAPI process. The RD will report on the measures implemented to the QAPI Committee which will monitor for effectiveness monthly times 3 months and quarterly times one year. The committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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 _____	08/21/2014

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 325	Continued From page 16 Interview with med aide#1on 8/21/14 at 11:00 AM revealed Resident #54 did refuse the med pass due to not liking any changes in her daily routine. Documentation of the refusals was not available for review. Documentation of administration of the med pass and MVI was not available for review.	F 325		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure serving plates were clean and ready for use and failed to maintain cleanliness of the lowraters on three of five kitchen units with a serving line. The findings included: Observations on 8/20/14 at 11:40 AM on the 200 hall unit kitchen revealed the stacked plates ready for service had dried debris and dried food on the inside of the plates. Five plates were clean out of the stack of 25 ready for service.	F 371	F-371 483.35 Food Procure, Store/Prepare/Serve - Sanitary It is the policy of this facility to ensure that serving plates are clean and ready for use. Lowraters will be clean and sanitary. How corrective action will be accomplished for those residents having potential to be affected by deficient practice Dietary Manager conducted in-service for	9/17/14

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 _____	08/21/2014

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 371	Continued From page 17 Five bowls out of 10 had dried debris on the inside ready for use. Dietary aide #1 removed the plates and bowls and placed them in the dishwasher on the unit. Inspection of the plates after being rewashed revealed no debris or food remained on the plates/bowls. Interview with the 200 hall dietary staff member #2 on 8/20/14 at 11:55 AM revealed the area around the plate warmer was wiped down every day. She had not wiped the lowrater down after each meal. 500 hall unit kitchen plates were observed on 8/20/14 at 12:02 PM. Two of the stacked plates had dried debris and were removed. Interview with the Dietary Manager on 8/20/14 at 12:02 PM revealed he would expect the dietary staff to inspect the dishes as they are removed from the dish machine and before use. The plate warmer area needs to be wiped down. He would have maintenance check the inside of the plate warmer to ensure it was cleaned. Observation of the dish lowrater on 300 hall unit kitchen on 8/21/14 at 10:20 AM revealed encrusted food debri and dried yellow/brown substance inside the lowrater. Pieces of what appeared to be broccoli were on the top of the lowrater where clean dishes were placed. Dishes were inspected and found to have dried food debris. There were five of the top ten plates with dried food debris. Interview with dietary staff #1 on 8/21/14 at 10:22 AM revealed the lowrater was positioned beside the steam table and under the serving window. Dietary staff #2 explained food spills may have	F 371	all Dietary Aides assigned to serve food in Households on proper dishware and equipment cleaning procedures. All Dietary Aides had received this in-service training by 8/26. Supervisory staff has been assigned to visit each household daily during mealtimes to inspect dishes and equipment for cleanliness. What measures will be put into place or system changes initiated to ensure that the deficient practice does not occur again All residents on all households have the potential to be affected therefore all dietary aides have received training and Supervisory staff are visiting each Dining area daily to inspect for dishware and equipment cleanliness. How facility will monitor effectiveness of plan ensuring that correction is achieved and maintained A quality improvement checklist will be completed by each Supervisor during daily inspections of each of the Household dining areas. Checklists will be completed daily on each household for one month and then weekly. Results of these inspections will be shared in daily huddle meetings with Dietary Aides. These measures will be monitored by the Food Service Director with oversight by the Administrator through the QAPI process. The Food Service Director will report on the measures implemented to the QAPI Committee which will monitor for effectiveness monthly times 3 months 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 _____	08/21/2014

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 371	Continued From page 18 occurred when plating food. Continued interview revealed the plates were from last night and the evening staff should have checked the plates and the lowrater. Interview with Dietary Manager on 8/21/14 at 10:30 AM revealed the lowrater should have been cleaned. There was a cleaning schedule for the lowrater and would be cleaned monthly.	F 371	then quarterly times one year. The committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that these recommendations are acted upon in a timely manner.	