| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345116 | A. Building<br>B. Wing | 10/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Piedmont Hills Center for Nursing and Rehab | 109 S Holden Road<br>Greensboro, NC 27407 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, Responsible Party interview, On-Call Nurse Practitioner interview, Nurse Practitioner interview, and Medical Director interview, the facility failed to notify the physician immediately after Resident #5 exhibited a change in condition related to a fall. Resident #5 had a low pulse during vital sign checks after the fall and Resident #5's Responsible Party identified a hematoma on the resident's head later in the day and requested he be sent to the hospital. The deficient practice affected 1 of 3 residents reviewed for accidents (Resident #5). The findings Included: Resident # 5 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy, abnormal findings on diagnostic imagining of skull and head, and dementia with behavioral disturbance.A review of the admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #5 was severely cognitively impaired. A review of the incident report dated 9/3/25 at 11:30 AM, written by Nurse #3 revealed Resident #5 had an unwitnessed fall in his room and was observed laying on the floor next to his bed with no injuries noted. Resident #5 was unable to describe the incident and was assessed and assisted back to the wheelchair.Review of Resident #5's Neurological Flow sheet dated 9/3/25, completed by Nurse #3 revealed neurological checks (a series of neurological observations and neurological system checks conducted by nursing staff to identify any signs or symptoms of a potential neurological abnormality) and vital sign checks were initiated at 11:30 AM. The flow sheet indicated vital signs, and neurological checks were to be completed as follows: Every 15 minutes for 1 hour; Every 30 minutes for 1 hour; Every hour for 4 hours; Every 4 hours for 24 hours. The flow sheet revealed neurological checks were completed on 9/3/25 at 11:30 AM, 11:45 AM, 12:00 PM, 12:15 PM, 12:30 PM, 12:34 PM, 1:15 PM and 5:15 PM. The flow sheet also revealed that Resident #5 experienced a low pulse of 56 beats per minute (bpm) (normal range between 60 bpm and 100 bpm) at 12:00 PM and again at 12:15 PM. Resident #5 was noted to have a blood pressure of 100 (systolic-heart contracting)/50 (diastolic-heart relaxed) (normal blood pressure would be 120/80) at 1:15 PM and refused the remaining blood pressure checks.An interview was conducted with Nurse #3 on 10/21/25 at 2:24 PM. Nurse #3 explained that the facility's protocol for monitoring a resident post fall was to follow the falls/incident form which instructs the nurse to complete a fall assessment, pain assessment, skin assessment, neurological checks for all witnessed and unwitnessed falls, update the care plan with a fall intervention, collect witness statements, update the 24-hour report and notify the Responsible Party (RP), the provider (the physician or physician extender such as a Nurse Practitioner (NP) or Physician's Assistant (PA), and the Director of Nursing . Nurse #3 further explained the nurses were trained to complete the facility's Neurological Flow sheet which directed the nurse to complete neurological checks and vital sign checks and to notify the provider of any change in condition. Nurse #3 further revealed she should have notified the provider when Resident #5 had a change in condition related to a low pulse rate of 56 beats per minute (bpm) that occurred on 9/3/25 at 12:00 PM and again at 12:15 PM. She explained she was not sure why it had not been done and that she must have just missed it.A review of the incident report dated 9/3/25 at 1:00 PM, written by Nurse #3 revealed Resident #5 had an unwitnessed fall and was at the nurse's station trying to pick something up off the floor when he fell forward out of the wheelchair and striking the left side of his head. The progress note further revealed Resident #5 was assessed and had no injury, signs or symptoms of pain, skin was intact, and the NP and RP were notified.A review of the Nurse Practitioner's (NP) progress note dated 9/3/25 at 1:00 PM revealed Resident #5 was seen in the facility for a follow up due to a fall. The progress note indicated that nursing staff reported Resident #5 was found lying on the right side of the floor by the bed with no injuries. The NP's progress notes further revealed the following vital signs dated 9/2/25 at 11:02 AM were reviewed: pulse of 72 beats per minute (bpm), systolic blood pressure of 122 and diastolic blood pressure of 68, oxygen saturation 95 at room air, 97.6 temperature and respiratory rate of 16 breaths per minute. There was no mention of the resident's low pulse readings of 56 bpm at 12:00 PM and 12:15 PM on 9/3/25.An interview was conducted with the NP on 10/22/25 at 11:08 AM. The NP indicated that it was her understanding that the facility's post fall protocol was for the nurse to initiate neurological and vital sign checks every 15 minutes for 1 hour; every 30 minutes for 1 hour; every hour for 4 hours; every 4 hours for 24 hours and to notify the provider of any changes or concerns. The NP recalled assessing Resident #5 after his first fall on 9/3/5 around lunchtime and was not made aware that Resident #5 had a low pulse rate at 12:00 PM and again 12:15 PM The NP further revealed that she would have wanted to have been aware of |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews of the staff, Family Member, Responsible Party, Paramedic, Nurse Practitioner (NP), Psychiatry NP, and Medical Director, the facility failed to identify the seriousness of new behaviors and increased confusion and complete and document thorough on-going assessments of a resident which delayed medical interventions and treatment. On 10/2/25 nursing staff were aware Resident #1 was undressing, which was a change for the resident and as the day progressed, he became more confused and agitated. A family member visited that evening and found the resident naked on the floor in his room. The family member reported to the nurse that the undressing was out of character for the resident, and he was agitated. The family member told the nurse she felt like something was wrong and asked the nurse to call 911. The nurse checked the resident's temperature, pulse and respirations which were within normal limits and told the family member they would take care of it. The family member returned at approximately 11:00 PM and found the resident naked on the floor again and called 911. Emergency Medical Services (EMS) transported Resident #1 to the hospital where he was diagnosed with acute encephalopathy (any disorder or disease affecting brain function), acute respiratory failure (a life- threatening impairment of oxygenation, carbon dioxide elimination or both) with hypoxia (low levels of oxygen in body tissue), hypotension (low blood pressure), lactic acidosis (excessive buildup of lactic acid in the blood), acute kidney injury (abrupt decrease in kidney function), and transaminitis (liver enzymes elevated), septic shock (a serious medical condition that occurs when an infection leads to extremely low blood pressure and organ failure) and aspiration pneumonia (an infection caused by inhaling food, liquid, saliva or stomach contents into the lungs). The resident was admitted to the intensive care and required fluid resuscitation and medication to maintain his blood pressure, antibiotic treatment, and 3 days of ventilator life support. Resident #1 was discharged from the hospital on [DATE]. In addition, the facility failed to complete thorough and ongoing assessments including neurological checks (a series of neurological observations and neurological system checks conducted by nursing staff to identify any signs or symptoms of a potential neurological abnormality) after a fall occurred which caused a delay in receiving further medical evaluation and treatment. The deficient practices affected 2 of 3 residents reviewed for professional standards and hospitalization (Resident #1 and Resident #5).The findings included:1. Resident #1 was admitted on [DATE] with the diagnoses of metabolic encephalopathy (the brain does not function properly) from poly pharmacy (many different medications), dysphagia and stroke.<br><br>Resident #1 had NP notes documented for 9/26/25 and 9/29/25. The notes documented the resident was alert to self and situation and was able to answer questions. The resident was participating in therapy. There were no behaviors reported.<br><br>The NP was interviewed on 10/21/25 at 11:20 am. The NP stated she saw Resident #1 on 9/26/25 and 9/29/25 as a new admit. The resident had intermittent confusion but was dressed and appropriate and able to answer questions. Staff reported the resident was cooperative. There was no report of him taking his clothing off, refusing care with combativeness, or wandering. There were no behaviors. The NP stated if the behaviors were new and not baseline, she would be concerned about infection and start testing. If the resident was not stable, she would send him out to the hospital.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A nurses' note dated 9/27/25 at 5:42 pm written by the Unit Manager documented Resident #1 had vital sign results for temperature 97.5 (normal value 96 to 99), pulse 74 (normal value 60 to 100) and regular, respirations 19 (normal value 12 to 20), and blood pressure was 121/68 (normal value 120/80). His oxygen saturation was 97.0 % (normal value 90 to 100%) on room air. The resident was alert with intermittent confusion. He had short term memory loss and usually understands and was understood. The resident had normal chest respirations, and his lungs were clear.<br><br>The Unit Manager was interviewed on 10/21/25 at 10:50 am. The Unit Manager stated she was assigned to Resident #1 on 9/27/25 during the day shift (7:00 am to 3:00 pm). The resident had intermittent confusion. The Unit Manager stated she had not recalled the resident removing his clothing, refusing care, or being combative. The resident was appropriate and cooperative. There was no nursing assistant (NA) report of confusion, combativeness, or clothing removal.<br><br>A nurses' note dated 9/29/25 at 7:17 pm by Nurse #1 documented Resident #1's vital sign results were temperature 97.2, pulse 73 and regular, respirations 8 and blood pressure 110/62. His oxygen saturation was 96.0 % on room air. The resident was alert with intermittent confusion. He had short term memory loss and usually understands and was understood. The resident had normal chest respirations, and his lungs were clear.<br><br>Nurse #1 was interviewed on 10/21/25 at 10:00 am. Nurse #1 stated she was assigned to Resident #1 on 9/29/25 during the evening shift (3:00 pm to 11:00 pm). He was a new admit and was oriented to self and situation. He was wearing his clothes.<br><br>The admission Minimum Data Set for Resident #1 dated 9/30/25 documented he had moderate cognitive impairment, clear speech, understands, and was understood, was feeling down, and had trouble falling asleep. Toileting required moderate/maximal assistance. The resident's diagnoses were stroke, hemiplegia (one sided weakness, communication/speech language deficit following stroke, and dysphagia.<br><br>Resident #1's care plan dated 9/30/25 documented the resident was a high risk for falls and had an actual fall with no injury. The interventions were to round frequently and offer care and a reminder for use of the call light. The resident had a swallowing deficit, and the interventions were for small bites and sips, no straws, and check after meals for food pocketing.<br><br>Resident #1's Psychiatric NP visit note dated 9/30/25 documented he was seen for an initial assessment. The resident was alert and oriented x 2 (self and situation) and calm and cooperative. He was new to the facility after hospital discharge for acute encephalopathy and had a history of cognitive communication deficit and insomnia. The resident was sitting in his room at the bedside. He reported feeling hopeless and down due to his health and being in a facility. The resident reported he had been engaging in activities at the facility and had been interacting with his roommate. The nursing staff had not reported any behavioral concerns. The resident had been seen by therapy.<br><br>The Psychiatric NP was interviewed on 10/22/25 at 11:10 am. The Psychiatric NP stated Resident #1 was wearing his clothing on 9/30/25 and there was no report from nursing about behaviors or the resident removing his clothing. The resident was oriented to person and situation, appropriate, and able to answer questions.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The Occupational Therapist note (OT) note dated 10/1/25 documented Resident #1 participated in upper and lower body exercises. The resident continued to need assistance and was compliant with skilled interventions.<br><br>On 10/22/25 at 1:52 pm an interview was conducted with the OT. The OT stated she was assigned to Resident #1 on 10/1/25 in the morning. His diagnoses were a stroke with spastic hemiplegia. The resident was alert and oriented to self and situation. He was dressed and appropriate. The OT indicated Resident #1 was able to follow commands and participate but was limited in answering questions and he seemed a little agitated.<br><br>Resident #1 had an admission progress dated 10/2/25 (time was not indicated on the note) written by the Medical Director. The progress note documented that the resident had a history of metabolic encephalopathy (the brain does not function properly) from medication and being found unresponsive by his roommate. The resident was alert but appeared confused after returning from therapy. There was no report from nursing of any complaints or concerns. The resident's judgement and insight was appropriate with a normal affect (facial expression). The resident is well developed (physical attributes are normal), in no acute distress, and lying in bed resting comfortably.<br><br>Resident #1's nurses' note 10/2/25 at 5:00 pm written by Nurse #1 documented Resident #1's vital sign results were temperature 97.4, pulse 74 and regular, and respirations 18. He was oriented to person and place with intermittent confusion. Nursing assistant (NA) #1 reported the resident disrobed and did not want to get dressed. There was no oxygen saturation documented in the record.<br><br>On 10/20/25 at 11:50 am the Family Member was interviewed. The Family Member stated she visited Resident #1 on 10/2/25 at 7:00 pm. Upon entering the resident's room, he was found naked, and the resident reported to the Family Member the nurse was asked to help him get dressed, but the assigned nurse (Nurse #1) replied she was not going to help him get dressed. The Family Member stated the resident was not acting his normal self. The Family Member asked Nurse #1 and she (Nurse #1) commented that the resident was not his normal self and the NA was asked to assist with the clothes. The Family Member informed Nurse #1 the resident had changed behavior, and undressing was out of character for him. The Family Member further reported something was wrong, he was agitated, and up and down. The Family Member reported to Nurse #1 she was going to call 911 and Nurse #1 asked family not to call 911, that the staff would take care of it. The Family Member indicated that she left and went home. The Family Member stated she discussed the resident's change in behavior with other Family Members, and they decided to return to the facility about 11:00 pm. The resident's door was closed and upon entry the resident was on the floor naked. He appeared to be asleep but was squirming on the floor. The resident answered to his name but was very confused. The Family Member called out to the nurse, the resident was on the floor and called 911. Staff assisted the resident back to the bed. This was the second time family found the resident naked that day. Emergency Medical Services (EMS) evaluated the resident, and he had a low oxygen level and was barely breathing. EMS informed the family they thought Resident #1 had an infection. The Family Member stated EMS informed her he would have died during the night if EMS had not been called.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 10/21/25 at 10:00 am Nurse #1 was interviewed. Nurse #1 stated she was assigned to Resident #1 on 10/2/25 evening shift from 3:00 pm to 11:00 pm. Nurse #1 stated early in the shift the family visited, and NA #1 would put the resident's clothes on, and the resident took his clothes off repeatedly. Nurse #1 stated she received nothing in report about this behavior. The resident was alert and verbal. When the family came in to visit around 4:00 pm the resident was different. The resident appeared mad and agitated versus anything being wrong with his mentation. Nurse #1 stated she took the resident's vital signs, and they were normal. Nurse #1 stated when she asked the resident about his clothing he replied, I don't want them on. Nurse #1 stated she had not thought the resident had a change in mental status. Nurse #1 indicated the resident was swatting their hands when he did not want something and had limited verbal communication which was a change for him.<br><br>On 10/22/25 at 2:37 pm Nurse #1 was interviewed again. Nurse #1 stated the family member came to visit Resident #1 on 10/2/25 at dinner time during her evening shift. The resident was not himself and the family member was concerned. The family member requested the resident be sent out to the hospital. Nurse #1 stated she took the resident's vital signs, and they were stable, and Nurse #1 decided not to report the family's concerns or request to medical staff. The family member reported to Nurse #1 that, the resident wasn't right and the family member went home. After dinner NA #1 informed Nurse #1 that the resident was more confused and agitated. Nurse #1 further stated this information was not provided to medical staff. Nurse #1 reported off to Nurse #2 the resident's behavior and that the family was in to visit.<br><br>On 10/21/25 at 1:40 pm NA #1 was interviewed. NA #1 stated she was assigned to Resident #1 on 10/2/25 from 3:00 pm to 11:00 pm and this was her first time having the resident. The resident was taking his clothing off and was not cooperative when she tried to put his clothing back on and took his clothing back off. NA #1 indicated, I heard another NA talking about the resident taking his clothes off on day shift (7:00 am to 3:00 pm) on 10/2/25, I received nothing in a formal report. NA #1 revealed the resident appeared very confused and was unable to follow directions and this was reported to Nurse #1 who was assigned to the resident. The family came in to visit at dinner time and was informed the resident had taken his clothing off. Nurse #1 took vital signs. NA #1 stated she was not familiar with the resident's mentation and was unsure if there was a change. The NA stated she reported the resident's behavior to the medication aide assigned also.<br><br>The Medication Aide was interviewed on 10/21/25 at 9:27 am. The Medication Aide stated he remembered Resident #1 taking his clothes off on 10/2/25 during day shift and night shift NA #3 (10/1/25) reported the same. At the beginning of day shift (7:00 am to 7:00 pm) on 10/2/25 the resident was alert and oriented. He was eating and taking his medications. Later in the shift the resident was less oriented, taking off his clothes, coming out to the hallway and taking off his undergarment. This behavior was similar to what was reported 10/2/25 from night shift on 10/1/25 from 7:00 pm to 7:00 am. The Medication Aide indicated he had not interacted with the family, did not see the family, and there were no reports that there were concerns about the resident's mentation. The resident was able to make his needs known but seemed confused and less verbal at the end of his shift at 7:00 pm. The Medication Aide stated he thought the increased confusion was the resident's baseline and there was no change in mentation for the resident documented in the nurse 24-hour report. Did the Medication Aide report the highlighted to you? If so would need to documented this way. Yes, changed<br><br>Attempts to interview NA #3, who was assigned to Resident #1 on 10/1/25 night shift 7:00 pm to 7:00 am, were unsuccessful.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident #1 had a nurses' note dated 10/3/25 at 3:59 am written by Nurse #2. Nurse #2 documented while in the hallway she heard yelling coming from Resident #1's room by the family member man on the floor at approximately at 11:06 pm. Nurse #2 noted Resident #1 on the floor next to his bed and was alert to self with signs and symptoms of confusion. The resident had no complaints about pain or discomfort. Emergency Medical Services (EMS) was contacted by staff, and the family member had called on his personal cell phone before notifying staff. The EMS arrived at around 11:15 pm and left with the resident at 11:30 pm on the stretcher with the family following behind. Nurse #2 was notified by NA #1 at around 10:50 pm that resident refused care and assistance with putting on his night grown. Nurse #2 also had the same issue with the resident at around 10:00 pm. Nurse #2 noted the resident was sitting on his bed without clothing. Nurse #2 tried to help the resident to lay down in bed by assisting his legs and he kicked and was shaking his head. The resident refused clothing also. The resident was left sitting in bed with the bed in the lowest position.<br><br>On 10/21/25 at 2:20 pm Nurse #2 was interviewed. Nurse #2 stated she was assigned to Resident #1 on 10/2/25 from 11:00 pm to 7:00 am. This was her first assignment with Resident #1. Nurse #2 received in report from evening shift that the resident had some confusion and had taken his clothes off, the family had visited, and to watch the resident closely. The resident had not allowed staff to provide care or to redress on Nurse #2's night shift. Nurse #2 indicated that NA #1 reported around 10:15 pm the resident was a little combative and confused during the evening shift. Nurse #2 stated she was not sure if the refusal of care, removing clothing and being combative for the NA during care was new. Nursing was responsible for determining a resident's orientation from the prior day if there was an altered mental status. Nurse #2 commented that some people have good or bad days, and she would need to return to evaluate the resident again when the resident was new. Staff would need to start monitoring a resident's mental status and talk to staff that may have had the resident previously or read notes to determine the resident's mental status. Nurse #2 revealed she had not looked back at the resident's record to determine his orientation and I did what I could in the timeframe.<br><br>EMS documentation dated 10/2/25 indicated they responded to a 911 call by the family for Resident #1 at the facility. Arrival time was 11:23 pm. The resident had signs and symptoms of an altered mental status, restlessness and agitation, and sepsis. The resident had a fall from the bed with no injury. Upon arrival the blood pressure was 96/54, pulse 100, respirations 12, and pain score by facial expression 6 (0 to 10 with 10 being the worst). EMS asked the resident what was wrong, and he responded dying. At 11:45 pm oxygen was administered by nasal cannula and pulse oximetry result was 95%. Sepsis treatment of fluid resuscitation and oxygen began at the facility and continued while enroute to the hospital.<br><br>On 10/22/25 at 2:20 pm an interview was conducted with the EMS paramedic. The paramedic stated she was called to the facility on [DATE] around 11:00 pm. The family member had called 911 when he found Resident #1 on the floor unresponsive at the facility. The family member informed Nurse #2 that he had not wanted to wait because the family had visited earlier at 5:00 pm and notified nursing there was something wrong. The facility called 911 after the family member had called. The resident was non-verbal, difficult to arouse, hypotensive (low blood pressure), and dyspneic (difficulty breathing). The resident met the protocol for sepsis (infection of the blood). The resident had sepsis treatment imitated by EMS and was transported to the Emergency Department (ED). The resident responded the one-word response when asked what was wrong, dying.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Resident #1's ED record revealed he arrived at the ED on 10/3/25. His ED record documented that he was found to have acute encephalopathy, acute respiratory failure with hypoxia, hypotension, lactic acidosis, acute kidney injury, and transaminitis. The resident had an unwitnessed fall at the facility and an altered mental status. The resident had a chest x-ray and was found to have aspiration pneumonia and a lab result of elevated white blood cells 12.9 (showing infection and/or inflammation, normal range 6-10), and a workup for sepsis. The resident had septic shock and required fluid resuscitation and medication to maintain his blood pressure, antibiotic treatment, intensive care, and 3 days of ventilator life support. Computed Tomography (CT) Scan (computerized x-ray imaging process) of the resident's chest on 10/3/25 showed moderate to advanced emphysema with diffuse bronchial inflammation and debris within the left mainstem bronchus (from aspiration). The resident's sepsis and pneumonia were resolved, and he was transferred to another facility 10/8/25.<br><br>On 10/21/25 at 1:06 pm an interview was conducted with the Medical Director. The Medical Director stated he saw Resident #1 on 10/2/25 early in the day and wrote a progress note. The resident had slight confusion but was able to answer questions. Nursing had not reported to the Medical Director that the resident had taken his clothes off and that he had new behavior. The Medical Director stated if a resident had a change in behavior or an altered mental status, he expected staff to take vital signs and check the blood glucose. If these values were normal for Resident #1, the staff would be expected to call the medical staff because this resident had a medication reaction previously with metabolic encephalopathy. The Medical Director stated he was not informed that the family visited in the evening and had concern the resident was undressing and confused, not himself, and asked that the resident be evaluated or that the resident had fallen and was sent to the hospital with an altered mental status that night. The Medical Director stated he expected the staff to notify him or the on-call provider for altered mental status, disrobing (new behavior) and be notified if the family felt there was a change in the resident's status and wanted him sent out to the hospital.<br><br>On 10/22/25 at 2:20 pm an interview was conducted with the Administrator. The Administrator stated she was not aware of Resident #1's mental status change reported by the family until after he was discharged to the hospital. She had no comment regarding the failure to report this to medical staff.<br><br>2. Resident # 5 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy, abnormal findings on diagnostic imagining of skull and head, and dementia with behavioral disturbances.<br><br>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was severely cognitively impaired and required partial/moderate staff assistance when attempting to stand from a sitting position.<br><br>Review of Resident #5's care plan created on 8/27/25 with revision dates of 9/1/25 and 9/3/25 revealed a focus area for actual fall with no injury related to poor balance, poor communication/comprehension, and unsteady gait. Initial interventions included anticipated resident needs, place call light within reach, provide prompt response to resident needs, and ensure resident had appropriate footwear in use when ambulating/mobilizing in wheelchair. On 9/1/25 an intervention was added to encourage Resident #5 to be up and out of bed before breakfast for supervision.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345116 | A. Building<br>B. Wing | 10/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Piedmont Hills Center for Nursing and Rehab | 109 S Holden Road<br>Greensboro, NC 27407 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of the incident report dated 9/3/25 at 11:30 AM, written by Nurse #3, revealed Resident #5 had an unwitnessed fall in his room and was observed laying on the floor next to his bed with no injuries noted. Resident #5 was unable to describe the incident and was assessed and assisted back to the wheelchair.<br><br>A review of nursing progress note dated 9/3/25 at 12:12 PM, written by Nurse #3, revealed Resident #5 was found lying on the floor next to the bed with no apparent injuries. Resident #5 was noted to have good range of motion to all extremities; no complaints of pain or discomfort were noted. Nurse #3 notified the Nurse Practitioner (NP) and Responsible Party (RP).<br><br>Review of Resident #5's Neurological Flow Sheet dated 9/3/25, completed by Nurse #3 revealed neurological checks (a series of neurological observations and neurological system checks conducted by nursing staff to identify any signs or symptoms of a potential neurological abnormality) and vital sign checks were initiated at 11:30 AM. The flow sheet indicated vital signs, and neurological checks were to be completed as follows: Every 15 minutes for 1 hour; Every 30 minutes for 1 hour; Every hour for 4 hours; Every 4 hours for 24 hours. The flow sheet revealed neurological checks were completed on 9/3/25 at 11:30 AM, 11:45 AM, 12:00 PM, 12:15 PM, 12:30 PM, 12:45 PM, 1:15 PM and 5:15 PM. The flow sheet also revealed that Resident #5 experienced a low pulse of 56 beats per minute (bpm) (normal range between 60 bpm and 100 bpm) at 12:00 PM and again at 12:15 PM.<br><br>A review of the NP's progress note dated 9/3/25 at 1:00 PM revealed Resident #5 was seen in the facility for a follow up due to a fall. The progress note indicated nursing staff reported Resident #5 was found lying on the right side of the floor by the bed. Resident # 5 was assisted to the wheelchair, was alert and nonverbal which was his baseline. The NP indicated she performed passive range of motion (ROM) with all extremities, no signs of acute pain, swelling or bruising were noted, pupils equal, round, reactive to light and accommodation, resident was not on an anticoagulant, no reported nausea, no change in appetite, resident remained restless, and neurological checks were initiated by nursing staff per facility's protocol. The NP's progress notes further revealed the following vital signs dated 9/2/25 at 11:02 AM were reviewed: pulse of 72 beats per minute (bpm), systolic blood pressure of 122 and diastolic blood pressure of 68, oxygen saturation 95 at room air, 97.6 temperature and respiratory rate of 16 breaths per minute.<br><br>An interview was conducted with the NP on 10/22/25 at 11:08 AM. The NP indicated that it was her understanding that the facility's post fall protocol was for the nurse to initiate neurological and vital sign checks every 15 minutes for 1 hour; every 30 minutes for 1 hour; every hour for 4 hours; every 4 hours for 24 hours and to notify the provider of any changes or concerns. The NP recalled assessing Resident #5 after his first fall on 9/3/5 around lunchtime and was not made aware that Resident #5 had a low pulse rate at 12:00 PM and again 12:15 PM. The NP further revealed that she could not recall if she was notified of Resident #5's 2nd fall but she would have wanted to have been aware of the change in vital signs at that time so she could have assessed Resident #5 further and determine if additional medical interventions were needed.<br><br>A review of nursing progress note dated 9/3/25 at 1:00 PM, written by Nurse #3 revealed Resident #5 was at the nursing station in a wheelchair and reached for the floor when he fell out of the wheelchair. Resident # 5 had no loss of consciousness, no complaints of pain, and his pupils were equal and reactive. No injuries were observed, and the NP and RP were notified.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of the incident report dated 9/3/25 at 1:00 PM, written by Nurse #3 revealed Resident #5 had an unwitnessed fall and was at the nurse's station trying to pick something up off the floor when he fell forward out of the wheelchair and striking the left side of his head. The progress note further revealed Resident #5 was assessed and had no injury, signs or symptoms of pain, skin was intact, and the NP and RP were notified.<br><br>A second Neurological Flow Sheet was initiated on 9/3/25 at 1:00 PM by Nurse #3. The flow sheet revealed neurological checks, and vital signs were completed by Nurse #3 at 1:00 PM, 1:15 PM, 1:30 PM, 1:45 PM, 2:15 PM, and 2:45 PM and the results indicated Resident #5 was fully conscious, hand grasps were equal and strong, had movement in all 4 extremities, and pupil reaction was brisk. Resident #5's pulse rating was documented to be within normal limits. Resident #5's speech was noted to be rambling which was his baseline.<br><br>An interview was conducted with Nurse #3 on 10/21/25 at 2:24 PM. Nurse #3 explained that the facility's protocol for monitoring a resident post fall was to follow the falls/incident form which instructs the nurse to complete a fall assessment, pain assessment, skin assessment, neurological checks for all witnessed and unwitnessed falls, update the care plan with a fall intervention, collect witness statements, update the 24-hour report and notify the RP, the provider, the Director of Nursing . Nurse #3 further explained that the nurses were trained to complete the facility's Neurological Flow sheet which directs the nurse to complete neurological checks and vital sign checks. Nurse #3 indicated she was the assigned nurse for Resident #5 on 9/3/25 from 7:00 AM to 3:00 PM. Nurse #3 indicated Nurse #4 took over for her at the end of her shift but could not recall what time the transition took place. Nurse #3 indicated Resident #5 had 2 falls that occurred during her shift on 9/3/2025 and this was reported to Nurse #4. She stated that the first fall occurred in Residents #5's room at 11:30 AM and it was unwitnessed. Nurse #3 recalled observing Resident #5 on the floor on the side of his bed. Nurse #3 indicated Resident #5 was fully assessed , had no injuries and the Director of Nursing , NP and the RP were notified. She also indicated that the NP was in the facility at the time of the first fall and was able to assess Resident #5 between the 1st and 2nd falls. The 2nd fall occurred on 9/3/25 at 1:00 PM and was witnessed either by Nurse #4 or the Staff Development Coordinator (SDC) who was the unit manager at that time and Nurse #3 recalled Nurse #4 reporting the incident to her. Nurse #3 indicated that she thought Nurse #4 completed the post fall assessment and Resident #5 was already assisted to the wheelchair when she was notified of the 2nd fall. Nurse #3 revealed she noted on the incident report that the 2nd fall was unwitnessed in error and that she did not obtain witness statements and did not report a low pulse rate of 56 at 12:00 PM and again at 12:15 PM to the medical provider at that time. Nurse #3 could not explain why she did not notify the NP of the low pulse rate, but it should have been reported to the provider at that time.<br><br>A telephone interview was conducted with the SDC on 10/23/25 at 12:30 PM and she did not recall witnessing Resident #5's falls on 9/3/35 or completing any documentation related to a fall.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | An interview was conducted with the RP on10/21/25 at 5:00 PM. The RP revealed she was notified of both Resident #5's falls that occurred on 9/3/25 and came to the facility at approximately 3:00 PM on 9/3/25 to check on the resident. The RP indicated upon her arrival Resident #5 was observed seated in his wheelchair at the nurse's station for monitoring and she did not observe any head injury at that time. The RP further explained that she assisted Resident #5 back to the room and did not recall any staff members that came to Resident #5's room to check on him between the hours of 3:00 PM and 5:00 PM and neither Nurse #3 or Nurse #4 had not come into the room to complete any neurological or vital sign checks from 3:00 PM until Resident #5 was sent to the hospital. The RP indicated that around 5:00 PM she had observed a large bump that had formed over Resident #5's left eye and slightly swollen lip and notified Nurse #4 when he entered Resident #5's room. The RP indicated that around 5:00 PM she requested Nurse #4 notify someone in charge that she wanted to speak to them as she felt that the staff had not been monitoring Resident #5 and may require hospitalization. The RP revealed the Director of Nursing (DON) came to Resident #5's room around 6:30 PM to discuss h |