

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Piedmont Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 610 West Fisher Street Salisbury, NC 28145	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>37281</p> <p>Based on record review and staff interviews, the facility failed to notify the physician of missed medication administration for 1 of 2 residents reviewed for notification (Resident #2).</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility 12/1/2021 with diagnoses including diabetes and hypertension.</p> <p>Review of the physician orders for Resident #2 revealed an order dated 12/1/2022 for glipizide (an oral hypoglycemic) 10 milligrams (mg) daily for diabetes.</p> <p>Review of Resident #2's medication administration record for December 2023 revealed the following dates were documented as not given and to see the nursing notes: 12/6/2023, 12/8/2023, 12/9/2023, 12/11/2023, and 12/14/2023.</p> <p>Nursing notes were reviewed for Resident #2 and the following was documented:</p> <p>12/6/2023 documented by Nurse #1: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: unavailable. The note did not document the physician had been notified the medication was not available.</p> <p>12/8/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the physician had been notified the medication was not available.</p> <p>12/9/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the physician had been notified the medication was not available.</p> <p>12/11/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the physician had been notified the medication was not available.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/14/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the physician had been notified the medication was not available.</p> <p>Multiple attempts were made to contact Nurse #2 for interview, but Nurse #2 did not return the calls.</p> <p>The former Director of Nursing (DON #1) was interviewed by phone on 7/22/2024 at 2:00 PM. DON #1 reported the facility had an automatic medication dispensing system that should have been stocked with routine medications for the residents and if the medication was not available, the physician should have been notified. The DON #1 reported she did not recall Resident #2 missing several doses of glipizide because the medication was not available and was not aware the physician was not notified.</p> <p>Nurse #1 was interviewed by phone on 7/22/2024 at 3:48 PM. Nurse #1 reported she was no longer employed at the facility, but she had administered medications to Resident #2 in the past. Nurse #1 explained if the facility did not have medications in stock, she would have called the pharmacy and the physician. When reviewing documentation Nurse #1 completed on 12/6/2023, Nurse #1 reported she had no memory of the incident and did not know why she had not called the physician.</p> <p>A phone interview was conducted with the facility physician (MD) on 7/23/2024 at 11:05 AM. The MD reported he had not been notified that glipizide 10 mg was not available for administration to Resident #2 and if he had been notified, he would have ordered a replacement medication. The MD explained that because Resident #2 was on other hypoglycemic medications, missing the 5 doses of the medication most likely had not harmed her, however, she should have received the medication, and he should have been notified she did not have 5 doses of the glipizide.</p> <p>The Director of Nursing (DON #2) and Assistant Director of Nursing (ADON) were interviewed on 7/23/2024 at 12:44 pm. DON #2 reported she and the ADON did not start working for the facility until 2024 and they were not in the building when Resident #2 missed her medications in December 2023. DON #2 explained the staff were educated to call the physician if a medication was not available to administer and she did not know why Nurse #1 and Nurse #2 had not contacted the MD about Resident #2's glipizide.</p> <p>The Regional Director of Clinical Services was interviewed on 7/23/2024 at 1:13 PM and she reported a mock survey was conducted in March 2024 and the survey discovered multiple issues with medication administration, including the physician was not notified for missed medications, and a plan of correction has been developed.</p> <p>The facility provided a plan of correction dated 3/28/2024 for unavailable medications.</p> <p>1. During Mock Survey on 3/26/2024 it was identified Physician/Responsible Party were not notified of missed medications.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. To identify residents that have the potential to be affected the Director of Nursing/Designee immediately reviewed 100% electronic medication administration records for the past six months to ensure all residents medications were administered as ordered. 100% of residents affected with the documentation of medications unavailable during different months during this review time. Responsible party/Guardians notified of findings. Medical Provider notified and reviewed findings and agrees no significant medication errors. A Quality Assurance Performance Improvement (QAPI) meeting was conducted on 3/27/2024 to discuss findings, develop the plan of correction, and initiate monitoring. A Root cause analysis determined the lack of notification of the Physician and Responsible Party were due to nursing staff not following the procedure to notify.</p> <p>3. To prevent this from happening again on 3/28/2024, the Director of Nursing/Designee completed education with 100% of Licensed Nursing Staff, Medication Aides and Current Agency Staff on the process of notification to the DON/Nurse Manager if any issues with obtaining medications, Notifying the Responsible Party if applicable, Notifying the Physician if unable to obtain the prescribed medication and request an interchange if available in the automated medication dispensing system. Licensed Nurses and Medication Aides educated on documentation and instructed not to use medication unavailable until all the above has been exhausted and Physician has given an order to hold until medication is available.</p> <p>Newly hired Licensed Nursing Staff to be educated during Orientation. Agency nursing to be educated before assigned shift on Medication Administration Guidelines.</p> <p>4. To Monitor and Maintain Ongoing Compliance the facility will do the following:</p> <p>The DON/Designee will audit the medication administration records 5x's a week for 12 weeks to ensure all medications guidelines are followed and in compliance and to ensure medical provider notified if any medication availability issues are identified.</p> <p>The Administrator will report the results of the audits to the QAPI committee for review and recommendations for a minimum of three months.</p> <p>Date of Compliance: 03/29/2024.</p> <p>The facility date of compliance of 3/29/2024 was validated on 7/23/2024 by review of the education provided to nursing staff and medication aides, reviewing audit forms, reviewing medication administration records and nursing notes, review of the QAPI meeting notes, and interviews with nursing staff, Physician, Director of Nursing, and Assistant Director of Nursing.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>37281</p> <p>Based on record review, observations, and staff interviews, the facility failed to provide routine medications for 1 of 3 residents reviewed for medication administration (Resident #2).</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility 12/1/2021 with diagnoses including diabetes and hypertension. The most recent quarterly Minimum Data Set assessment assessed Resident #2 to be moderately cognitively impaired.</p> <p>Review of the physician orders for Resident #2 revealed an order dated 12/1/2022 for glipizide (an oral hypoglycemic) 10 milligrams (mg) daily for diabetes.</p> <p>Additionally, physician orders for Resident #2 included the following hypoglycemic medications:</p> <p>Victoza 1.2 mg subcutaneous daily for diabetes ordered 11/11/2023</p> <p>Metformin 1000 mg orally twice daily for diabetes ordered 12/1/2022</p> <p>Sliding scale insulin as needed 3 times per day ordered 11/11/2023: give 2 units of insulin for blood sugars 200-250; give 4 units of insulin for blood sugars 251-200; give 6 units of insulin for blood sugars 301-350; give 8 units of insulin for blood sugars 351-400; give 10 units of insulin for blood sugars 401-450; give 14 units of insulin for blood sugars greater than 451 and call the physician.</p> <p>Review of the medication administration record for December 2023 revealed the following dates glipizide 10 mg was documented as not given and to see the nursing notes: 12/6/2023, 12/8/2023, 12/9/2023, 12/11/2023, and 12/14/2023.</p> <p>Nursing notes were reviewed for Resident #2 and the following was documented:</p> <p>12/6/2023 documented by Nurse #1: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: unavailable. The note did not document the pharmacy had been contacted for refills.</p> <p>12/8/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the pharmacy had been contacted for refills.</p> <p>12/9/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the pharmacy had been contacted for refills.</p> <p>12/11/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the pharmacy had been contacted for refills.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12/14/2023 documented by Nurse #2: glipizide 10 mg: give 10 mg by mouth one time a day for diabetes: none on hand. The note did not document the pharmacy had been contacted for refills.</p> <p>Blood glucose results for Resident #2 were reviewed with the following results: (normal results from 70-120)</p> <p>12/6/2023: 5:36 AM 423 10 units of sliding scale insulin given</p> <p>12/6/2023: 12:19 PM 423 10 units of sliding scale insulin given</p> <p>12/6/2023: 4:35 PM 281 4 units of sliding scale insulin given</p> <p>12/8/2023: 6:09 AM 231 2 units of sliding scale insulin given</p> <p>12/8/2023 11:16 AM 254 4 units of sliding scale insulin given</p> <p>12/8/2023 5:03 PM 225 2 units of sliding scale insulin given</p> <p>12/9/202: 7:01 AM 211 2 units of sliding scale insulin given</p> <p>12/9/2023: 10:37 AM 255 4 units of sliding scale insulin given</p> <p>12/9/2023: 3:56 PM 236 2 units of sliding scale insulin given</p> <p>12/11/2023: 5:42 AM 165 no sliding scale insulin given</p> <p>12/11/2023: 11:16 AM 253 4 units of sliding scale insulin given</p> <p>12/11/2023: 4:36 PM 163 no sliding scale insulin given</p> <p>12/14/2023: 3:56 PM 235 2 units of sliding scale insulin given</p> <p>A pharmacy report of medication orders for Resident #2 in December 2023 documented glipizide 10 mg had been delivered on 12/18/2023.</p> <p>Multiple attempts were made to contact Nurse #2 for interview, but Nurse #2 did not return the calls.</p> <p>The former Director of Nursing (DON #1) was interviewed by phone on 7/22/2024 at 2:00 PM. DON #1 reported the facility had an automatic medication dispensing system that should have been stocked with routine medications for the residents. DON #1 explained staff nurses were instructed to look in the automatic medication dispensing system, then call the pharmacy and ask for the medication to be sent to the facility. DON #1 reported she did not recall Resident #2 missing several doses of glipizide because the medication was not available.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nurse #1 was interviewed by phone on 7/22/2024 at 3:48 PM. Nurse #1 reported she was no longer employed at the facility, but she had administered medications to Resident #2 in the past. Nurse #1 explained if the facility did not have medications in stock, she would have called the pharmacy and the physician. When reviewing documentation Nurse #1 completed on 12/6/2023, Nurse #1 reported she had no memory of the incident and did not know why she had not called the pharmacy.</p> <p>A phone interview was conducted with the facility physician (MD) on 7/23/2024 at 11:05 AM. The MD explained that because Resident #2 was on other hypoglycemic medications, missing the 5 doses of the medication most likely had not harmed her, however, she should have received the medication, and the pharmacy should have been notified the medication was not available.</p> <p>A Pharmacist was interviewed by phone on 7/23/2024 at 11:31 AM. The Pharmacist explained that the facility was using an automated refill system for routine medications that required completion of a form every month for the refills to be completed. The Pharmacist explained the automated refill process would not be completed if the form was incomplete, and the pharmacy records indicated the refill request for October and November 2023 were not completed and the refills were cancelled. The Pharmacist reported the automatic medication dispensing system had glipizide available as a stock medication and the facility had refilled the automatic medication dispensing system with 10 tablets of glipizide 10 mg on 12/10/2023, but they had not taken any out of the automatic medication dispensing system. The Pharmacist revealed no calls were documented from the facility from 12/6/2023 to 12/14/2023 requesting a refill of glipizide for Resident #2, and no medications were removed from the automatic medication dispensing system for her in December 2023.</p> <p>The Director of Nursing (DON #2) and Assistant Director of Nursing (ADON) were interviewed on 7/23/2024 at 12:44 pm. DON #2 reported she and the ADON did not start working for the facility until 2024 and they were not in the building when Resident #2 missed her medications in December 2023. DON #2 explained the ADON was completing the automated refill requests for the facility, so no refills were omitted. The ADON reported a daily report of missed medications was reviewed every morning to ensure that all residents were receiving their medications as the physician ordered.</p> <p>The Regional Director of Clinical Services was interviewed on 7/23/2024 at 1:13 PM and she reported a mock survey was conducted in March 2024 and the survey discovered multiple issues with medication administration, including the pharmacy was not being contacted for medications that were not in-house or stocked in the automatic medication dispensing system and a plan of correction has been developed.</p> <p>The facility provided a plan of correction dated 3/28/2024 for unavailable medications.</p> <p>1. During Mock Survey on 3/26/2024 multiple documentations of medication unavailable in resident electronic medical records were identified.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. To identify residents that have the potential to be affected the Director of Nursing/Designee immediately reviewed 100% electronic medication administration records for the past six months to ensure all residents medications were administered as ordered. 100% of residents affected with the documentation of medications unavailable during different months during this review time. Provider, Responsible party/Guardians (RP) were notified of findings and completed by 3/29/2024. A Quality Assurance Performance Improvement (QAPI) meeting was conducted on 3/27/2024 to discuss findings, develop the plan of correction, and initiate monitoring. A Root cause analysis determined missed medications were due to nursing staff not following the procedure to obtain medications that were not in the medication cart, the medication storage room, or in the automated medication dispensing system.</p> <p>3. To prevent this from happening again, on 3/27/2024, the Director of Nursing/Designee completed education with 100% of Licensed Nursing Staff and Current Agency Staff on the process of obtaining and administering medications .The education is inclusive of the process for ordering medication when supply is low, checking the medication storage room for over stock medications, using the automated medication dispensing system, to identify if medication is available, Notifying the pharmacy for STAT delivery to the facility, Notification to the DON/Nurse Manager if any issues with obtaining medications, Notifying the RP if applicable, Notifying the Provider if unable to obtain the prescribed medication and request an interchange if available in the automated medication dispensing system. Licensed Nurses and Medication Aides were educated on documentation and instructed not to use medication unavailable until all the above has been exhausted and Provider has given an order to hold until medication is available.</p> <p>Newly hired Licensed Nursing Staff to be educated during Orientation. Agency nursing to be educated before assigned shift on Medication Administration Guidelines.</p> <p>4. To Monitor and Maintain Ongoing Compliance the facility will do the following:</p> <p>The DON/Designee will audit the medication administration records 5x's a week for 12 weeks to ensure all medications guidelines are followed and in compliance.</p> <p>The Administrator will report the results of the audits to the QAPI committee for review and recommendations for a minimum of three months.</p> <p>Date of Compliance: 03/29/2024.</p> <p>The facility date of compliance of 3/29/2024 was validated on 7/23/2024 by observation of medication administration, review of the education provided to nursing staff, reviewing audit forms, reviewing medication administration records, nursing notes, review of the QAPI meeting notes, and interviews with nursing staff, Physician, Director of Nursing, and Assistant Director of Nursing. A medication administration observation was conducted 7/22/2024 and 7/23/2024. The facility had 0 errors out of 25 opportunities.</p>		