STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Health & Rehab Center	610 West Fisher Street Salisbury, NC 28145

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and resident and staff interviews, the facility failed to ensure a resident was spoken to in a dignified manner when the resident expressed feelings of being frustrated and felt like he was spoken to in a childlike manner. This affected 1 of 3 residents reviewed for dignity and respect (Resident #30). The findings included:Resident #30 was admitted to the facility on [DATE]. Resident #30's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact. The resident was not documented as having behaviors.An observation was conducted during a resident council meeting on 09/10/25 at 2:25 PM in a small room with ten residents present sitting facing the Activity Assistant. The door to the room was opened to the hall. Resident #30 voiced the door needed to be closed during the meeting for privacy. Resident #30 attempted to explain to the Activity Assistant the door to the room needed to be closed so that the meeting could be private and issues could be discussed privately. The Activity Assistant was sitting in a chair and told Resident #30 to calm down in a condescending tone and did not shut the door. Resident #30 was observed shaking his head, and had a furrowed brow, and raised his voice stating, She [The Activity Assistant] did not listen to the residents, and I am tired of being spoken to like a child. The Activity Assistant then rolled her eyes and stated to Resident #30 again to calm down. Resident #30 and other residents appeared to have a confused look on their faces and did not say anything to the Activity Assistant. The Activity Assistant excused herself from the meeting to allow the residents to have a private meeting without staff present. The Activity Assistant shut the door on her way out. An interview conducted Resident #30 on 09/11/25 at 8:45 AM revealed on 09/10/25 he got upset because he felt that the Activity Assistant spoke to him like a child when she told him to calm down and felt she could care a less what concerns residents had. Resident #30 indicated he was frustrated and was glad the Activity Assistant had left the meeting so that residents could speak freely and not feel like anything would be used against them. An interview with the Activity Assistant on 09/11/25 at 8:40 AM revealed she did not usually participate in resident council meetings but had been conducting them because the Activity Director had been out since the beginning of August. The Activity Assistant indicated on 09/10/25 during the resident council meeting she was surprised Resident #30 had gotten upset because she did not think she had acted toward resident in a negative manner. The Activity Assistant revealed she was not aware she had spoken to the resident in an undignified manner nor was she aware she had rolled her eyes. The Activity Assistant stated if she did roll her eyes or have a tone it was because she was caught off guard and was shocked when Resident #30 had been so vocal. It was further revealed she told Resident #30 to calm down because she felt that he was getting worked up. In an interview with the Administrator on 09/11/25 at 2:20 PM she revealed she expected staff to walk away if situations escalated and not to reply in an unprofessional manner. It was further revealed she expected all staff to treat residents with dignity and respect.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to update 2 of 3 residents advance directive information (Resident #15 and Resident #18).The findings included: 1. Resident #18 was admitted to the facility on [DATE]. A review of Resident #18's orders for advance directives revealed a physician's order dated [DATE] for Do Not Resuscitate (DNR, an order signed by a doctor that informs healthcare providers not to perform cardiopulmonary resuscitation (CPR) if a person's breathing stops or their heart stops beating). A review of Resident #18's face sheet and Medical Orders for Scope of Treatment (MOST) form dated [DATE], and both indicated he was a full code (meaning to perform life saving measures including CPR). An interview conducted with the Assistant Director of Nursing (ADON) on [DATE] at 12:10 PM revealed Resident #18 was initially admitted with orders to be a DNR but was recently changed to a full code status. The ADON further revealed she and the Director of Nursing (DON) updated and reviewed orders and should have caught that Resident #18's advance directives order had not been updated. During an interview conducted with the Director of Nursing (DON) on [DATE] at 9:20 AM, the DON stated Resident #18's physician order, face sheet, and MOST form should have matched. The DON further revealed the order in Resident #18's chart should have been updated to reflect the current MOST form for the resident to be a full code. An interview conducted with the Administrator on [DATE] at 2:20 PM revealed she expected advance directive information to match so that nursing staff had no confusion about what to follow in case of an emergency. It was further revealed Resident #18's physician order should have been updated to accurately match the resident's choice for code status. 2. Resident #15 was admitted to the facility on [DATE] with diagnosis of a seizure disorder. During a review of Resident #15's orders for advance directives a physician's order dated [DATE] indicated he was a full code. A review of Resident #15's face sheet, Do Not Resuscitate Form, and Medical Orders for Scope of Treatment (MOST) form were dated [DATE] and indicated he was a Do Not Resuscitate. An admission Minimum Data Set assessment dated [DATE] indicated Resident #15 was cognitively intact. On [DATE] at 9:56 AM Nurse #1 was interviewed, and she stated Resident #15's face sheet stated he was a DNR, and his physician's orders indicated he was a full code. Nurse #1 stated Resident #15's face sheet, Do Not Resuscitate form, and the physician's orders should match. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Assistant Director of Nursing on [DATE] at 12:04 PM and she stated each time a residents' code status changed she updated the book (where the DNR forms are kept at the nurses' station) to reflect the change. The book, face sheet and physicians' orders should match to reflect the residents' advance directives wishes. The Assistant Director of Nursing stated Resident #15's advance directives were to be DNR, but she failed to update the advance directives physician's order in the computer. The Director of Nursing (DON) was interviewed on [DATE] at 11:53 AM and she stated Resident #15's advanced directives physician's orders, face sheet, and the DNR form should have matched. The DON stated the physician's order should have been updated by the Assistant Director of Nursing when the DNR form was signed by the physician. On [DATE] at 1:45 pm the Administrator was interviewed and stated the nursing staff should ensure each residents' advance directives matched in the advance directives book at the nurses' station, and on the resident's face sheet and physician's orders to ensure the nurses were aware of the correct advance directives for each resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to provide nail care for 3 of 4 residents that were dependent on staff for personal care (Resident #2, Resident #26, and Resident #18). Findings included: 1. Resident #2 was admitted to the facility on [DATE] with heart disease and weakness. A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #2 was cognitively intact and required extensive assistance for personal hygiene. The assessment documented the resident did not have impairment to range of motion for the upper extremities. On 9/8/2025 at 11:43 am Resident #2 was observed in his room in bed, he had a dark brown substance under his nails, and the free edge of the nails were approximately 1/4 inch beyond the tip of the fingers for all 10 fingers. Resident #2 stated he received a shower twice a week and on days he does not receive a shower he was given a bed bath, but they did not clean under his nails after his showers, or after a bed bath, and he did not like for his nails to be long and dirty. On 9/8/2025 at 11:59 am an interview was conducted with Nurse Aide #2 who was assigned to Resident #2. Nurse Aide #2 stated Resident #2 required extensive assistance with nail care but did not refuse care. She stated Resident #2 was not scheduled for a shower on 9/8/25. She explained she had not noticed his nails had a dark brown substance under them and that they were long. Nurse Aide #2 stated Resident #2 did not tell her his nails needed to be trimmed and cleaned. An interview was conducted with Nurse #1 on 9/10/2025 at 9:43 am and she stated the Nurse Aides were responsible for cleaning and trimming residents' nails during their showers and when needed. During an interview with the Assistant Director of Nursing on 9/10/2025 at 9:52 am she stated the Activities Department does provide manicures on Thursday for residents that request a manicure, but the Nurse Aides should be cleaning and trimming the residents' nails when they provide the residents' showers as scheduled. The Director of Nursing was interviewed on 9/11/2025 at 11:57 am and stated the nurse aides and nurses were responsible for cleaning and trimming residents' nails with each shower and as needed. On 9/11/2025 at 1:45 pm the Administrator was interviewed, and she stated the residents' nails should be cleaned and trimmed with each shower and as needed. 2. Resident #26 was admitted to the facility on [DATE] with diagnoses of fracture of the right humerus (the bone in the upper arm), stroke, and hemiplegia (weakness of one side of the body). An admission Minimum Data Set assessment dated [DATE] indicated Resident #26 was cognitively intact and required extensive assistance for personal hygiene. The assessment further indicated Resident #26 had weakness to his upper and lower extremities on one side. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident #26 on 9/8/2025 at 12:39 pm the free edge of his fingernails were approximately 1/4 inch beyond the tip of the finger and he stated his nails were trimmed when he was admitted to the facility but had not been trimmed since his admission. Resident #26 stated he did not like his nails to be long. On 9/8/2025 at 11:59 am an interview was conducted with Nurse Aide #2 who was assigned to Resident #26. Nurse Aide #2 stated Resident #26 was dependent on staff for nail care and all personal hygiene, and he did not refuse nail care. Nurse Aide #2 stated she had not given Resident #26 a shower on the day of the interview and was not aware his fingernails extended approximately 1/4 inch long beyond fingertips. Nurse Aide #2 stated Resident #26 did not tell her his nails needed to be trimmed. An interview was conducted with Nurse #1 on 9/10/2025 at 9:43 am and she stated the Nurse Aides were responsible for cleaning and trimming residents' nails during their showers and when needed. During an interview with the Assistant Director of Nursing on 9/10/2025 at 9:52 am she stated the Activities Department does provide manicures on Thursday for residents that request a manicure, but the Nurse Aides should be cleaning and trimming the residents' nails when they provide the residents' showers as scheduled. The Director of Nursing was interviewed on 9/11/2025 at 11:57 am and stated the nurse aides and nurses were responsible for cleaning and trimming residents' nails with each shower and as needed. On 9/11/2025 at 1:45 pm the Administrator was interviewed, and she stated the residents' nails should be cleaned and trimmed with each shower and as needed. 3. Resident #18 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes, acute kidney failure, muscle weakness, chronic pain, and hypertension. Resident #18 quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact and required substantial and maximal assistance with personal hygiene. Resident #18's care plan revised on 07/15/25 revealed the resident was at risk for activities of daily living (ADL) self-care and mobility deficits. Resident #18's goal was his needs would be met with assistance if needed. Interventions included to check Resident #18's nail length, trim, and cleaning as needed. An interview and observation conducted with Resident #18 on 09/08/25 at 11:50 AM revealed the resident voiced complaints that his fingernails were long, and he had recently asked staff to trim them, but they had not been trimmed yet. Observations further revealed Resident #18's fingernails to be an estimated one inch long from the base to the tip of the nail with a brown substance under his nails. Resident #18 stated Nurse Aides (NAs) would not trim his fingernails because he was diabetic. An interview conducted with Nurse Aide (NA) #5 on 09/10/25 at 10:55 AM revealed she did not perform nail care on Resident #18 due to the resident being a diabetic. NA #5 further revealed she assisted Resident #18 with bathing and other hygiene needs but could not recall the length and shape of his nails. NA #5 stated the Activity Director (AD) or Nurses performed nail care for diabetic residents. NA #5 revealed if she had observed Resident #18's fingernails to be long she would have reported it to the assigned Nurse. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with the Assistant Director of Nursing (ADON) on 09/09/25 at 12:10 PM revealed she had trimmed Resident #18's fingernails on this date due to being long. The ADON indicated that the Activity Director (AD) had been out of work since the beginning of August and normally did rounds and conducted nail care for all residents. The ADON stated Resident #18 had diabetes and Nurse Aides (NA) were not permitted to perform the care. ADON revealed the NAs should have reported long fingernails to nurses to assure nail care was being provided. Interview conducted with the Director of Nursing (DON) dated 09/01/25 at 10:35 AM revealed she was not aware Resident #18's fingernail had not been trimmed. The DON further revealed she expected all staff to observe residents and complete hygiene needs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to post cautionary signage for oxygen in use for 2 of 3 residents reviewed for respiratory care (Resident #25 and Resident #38).Findings included: 1. Resident #25 was admitted to the facility on [DATE] with diagnosis of respiratory disease. A Physician's Order dated 8/22/2025 indicated Resident #25 should be administered 2 liters of oxygen by nasal canula continuously. A Minimum Data Set admission assessment was in progress but not completed for Resident #25. The care plan for Resident #25 dated 8/22/2025 indicated he required oxygen continuously for respiratory disease. On 9/8/2025 at 12:27 pm an observation was conducted of Resident #25, and he was in bed, and his oxygen was delivered by nasal canula. Resident #25 did not have signage to designate he had oxygen in use posted on his room door. On 9/10/2025 at 10:00 am an observation was made of Resident #25 in bed with his oxygen delivered by nasal canula, without signage on his room door to designate he was on oxygen. Nurse #1 was interviewed on 9/10/2025 at 10:03 am and she stated Resident #25 should have an oxygen sign on his door and the nurse was responsible for placing the oxygen in use signage on the resident's door. Nurse #1 stated Resident #25 had orders for continuous oxygen. The Hospice Nurse was interviewed on 9/10/2025 and she stated Resident #25 was required hospice services due to a diagnosis of chronic respiratory disease and required oxygen continuously for comfort. During an interview with the Director of Nursing on 9/11/2025 at 11:57 am she stated Resident #25 should have signage to designate he had oxygen on his room door since he received oxygen, and the nursing staff was responsible for ensuring the signage was on the resident's room door. An interview was conducted with the Administrator on 9/11/2025 at 1:45 pm and she stated residents that receive oxygen should have signage on their door designating they were on oxygen. 2. Resident #38 was admitted to the facility on [DATE] with diagnoses which included unspecified acute lower respiratory infection, acute cough, wheezing, and congestive heart failure. Resident #38's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact. Physician order dated 09/08/25 revealed Resident #38 was ordered oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 09/09/25 at 12:25 PM revealed Resident #38 was observed in her room sitting in her wheelchair with oxygen on. The Resident stated she was getting ready to leave for an outing. The observation indicated no oxygen signage outside the door. An observation on 09/10/25 at 10:00 AM revealed Resident #38 was observed in her room sitting in her wheelchair with oxygen on. The observation further revealed no oxygen signage outside the door. An observation and interview conducted with the Assistant Director of Nursing (ADON) on 09/10/25 at 11:40 AM indicated she was not aware Resident #38 did not have any oxygen signage up. The ADON further revealed she and the Director of Nursing (DON) normally post oxygen signage but must have missed it. The ADON indicated all residents who received oxygen were expected to have oxygen signage. An interview conducted with the Director of Nursing (DON) 09/11/25 at 9:20 AM revealed they were unaware Resident #38 did not have oxygen in use signage posted outside of their room. The DON indicated she was aware Resident #38 had been using continuous oxygen. It was further revealed the DON expected staff to ensure signage was posted when there was oxygen in use, or in resident rooms.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, and Dietitian and staff interviews, the facility failed to label and date leftover food items stored for use in 1 of 1 walk-in cooler, 1 of 1 walk-in freezer and the dry goods storage area and failed to maintain clean food service equipment and flooring and failed to clean a thermometer probe before inserting the probe into food. These practices had the potential to affect food served to residents. The findings included:a. An observation of the walk-in refrigerator on 9/8/25 at 10:30 AM revealed an undated package of sliced ham that was not sealed. b. An observation on 9/8/25 at 10:41 AM revealed an open-to-air bag of chicken patties sitting in an open box, in the walk-in freezer and 4 bags of leftover hoagie rolls unlabeled and undated. c. An observation of the dry goods storage room on 9/8/25 at 10:50 AM revealed a bag of breadcrumbs in a clear plastic bag that was unlabeled and undated. An interview with the Dietary Manager (DM) on 9/8/25 at 10:53 AM indicated that whichever staff opened the packages they should label and date immediately when they are opened. She further stated that when taking the opened boxes from the kitchen to the freezer they should be inspected to make sure they were securely closedd. An observation of the plate covers on 9/10/25 at 11:57 AM prior to serving the line revealed the plate covers were dirty with food crumbs.e. An observation on 9/10/25 at 12:00 PM revealed [NAME] #1 removed a thermometer stored in a pitcher of ice to obtain the internal temperature of foods items. The thermometer probe was noted to have yellow food particles; the [NAME] proceeded to insert the thermometer probe into the creamed corn. [NAME] #1 did not clean the thermometer probe before inserting it into the creamed corn.An interview with [NAME] #1 on 9/10/25 at 12:00 PM indicated when asked about the cleaning of the thermometer, she said she was nervous and forgot to clean the probe and that she had just tested the food temperatures with the Dietitian and was trying to get the food ready to serve on time.An interview with the Dietary Manager on 9/10/25 at 12:26 PM revealed that the Dietitian had been in the kitchen prior and checked the food temperatures and that was why the thermometer probe contained food particles. She then revealed that [NAME] #1 had worked in the kitchen for 15 years and was just nervous, that she had done this thousands of times and always had her cloth and alcohol swabs laid out to clean the thermometer probe.An interview with the Dietitian on 9/10/25 at 3:00 PM indicated that she had been in the kitchen and had tested the food temperatures and that [NAME] #1 usually followed the correct procedure for taking the temperature of foods. f. Observations of the tea and coffee machines on 9/8/25 at 11:00 AM and 9/10/25 at 11:50 AM revealed the machines had dried splattered stains and sticky to touch substances on the outside walls and dried brown matter on the bottom. g. The dry goods storage area flooring was observed on 9/10/25 at 11:53 AM to have dirt, food debris and dust underneath the shelves. An Interview with the Dietary Manager on 9/10/25 at 2:54 PM revealed that the weekend staff did not clean well and she had to have a discussion with them so that they did a better job with cleaning. The DM further indicated that the dry good storage area floors were to be cleaned daily.An interview with the Administrator on 9/10/25 at 3:30 PM indicated that she expected the procedures in the kitchen to be correct and careful attention paid to food service to make sure the food not only tasted good but was sanitary and safe. The Administrator further stated she would talk with the Dietary Manager to make sure these corrections were made.