STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425314	A. Building B. Wing	04/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Post-Acute	109 Bentz Road Piedmont, SC 29673

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure staff checked temperatures of all foods placed on the steam table for hot holding prior to meal service. Specifically, staff failed to check temperatures of additional batches of food added to the steam table during meal service on 04/03/2026. This had the potential to affect 80 residents who received food from the facility kitchen. Findings included: Review of a facility policy titled, Serving Temperatures for Hot and Cold Foods, effective 2020, revealed, The cook will take temperatures of hot and cold food items using approved food thermometers prior to each meal service. During an observation on 04/03/2026 at 12:36 PM, Dietary Aide (DA)21 placed a new batch of fried chicken on the tray line and plated a plate for a resident and did not take the temperature of the fried chicken. The Assistant Dietary Director (ADD) asked DA21 if she took the temperature of the chicken and DA21 revealed she did not. During a continued observation of the tray line for lunch on 04/03/2026 at 12:55 PM, a new pan of macaroni and cheese was taken out of the oven, placed on the tray line, and plated. DA21 did not take the temperature of the macaroni and cheese, prior to service. During a continued observation of the tray line for lunch on 04/03/2026 at 12:56 PM, a new batch of fried chicken was taken out of the fryer and put on the tray line and plated. DA21 did not take the temperature of the fried chicken. During a concurrent observation and interview on 04/03/2026 at 12:40 PM, DA21 indicated, I do not like serving cold food, I had multiple batches of fried chicken because I like the food to be fresh. During an interview on 04/04/2026 at 12:36 PM, the Administrator revealed the expectation are the dietary department should be meeting all temperature guidelines. The Administrator stated that if additional food was prepared, its temperature must also be taken.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to ensure staff followed infection control practices to help prevent the development and transmission of communicable diseases and infections, which affected 1 of 1 resident, (Resident (R)92), reviewed for tracheostomy care, 1 of 1 resident, (R9), reviewed for pressure ulcers, and 1 of 1 resident, (R87), reviewed for transmission based precautions. The facility also failed to implement a complete water management program for Legionella prevention, which had the potential to affect all the residents in the facility. Findings included: 1. Review of a facility policy titled, Tracheostomy Care, revised 10/2023, revealed, The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas. The policy revealed, Procedure Guidelines included, 8. Remove old dressings. Pull soiled glove over dressing and discard into appropriate receptacle, and 9. Perform hand hygiene. An admission Record revealed the facility admitted R92 on 03/25/2026. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of acute and chronic respiratory failure with hypoxia and tracheostomy status. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/01/2026, revealed R92 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. Review of R92's Care Plan Report included a focus area initiated on 03/28/2026, that indicated the resident had a diagnosis of respiratory failure and indicated that the resident required tracheostomy care and monitoring. Interventions directed staff to manage the resident's artificial airway (initiated 03/28/2026). Review of R92's Order Summary Report, with active orders as of 04/03/2026, revealed an order, dated 03/23/2026, for tracheostomy care every shift. During an observation of R92's tracheostomy care on 04/01/2026 at 9:05 AM, the Respiratory Therapist performed hand hygiene, donned a pair of clean gloves, opened sterile supplies for tracheostomy care, and discarded the gloves. The Respiratory Therapist failed to perform hand hygiene prior to putting on sterile gloves that were within the kit. The Respiratory Therapist then removed the dressing from around the resident's neck and the tracheostomy collar and discarded it. The Respiratory Therapist then, wearing the same gloves, completed cleaning of the tracheostomy area. The Respiratory Therapist did not change gloves and/or perform hand hygiene between removing the dressing and cleaning the area. During an interview on 04/01/2026 at 9:20 AM, the Respiratory Therapist stated that when changing gloves, she was expected to perform hand hygiene between gloves changes. She stated that once she touched the dressing and removed it from around the resident's neck, it was considered dirty, and a new pair of sterile gloves should have been donned. She stated she had been trained and was expected to perform tracheostomy care per the facility's policy and procedures. During an interview on 04/04/2026 at 12:35 PM, the Director of Nursing (DON) stated that staff were required to wash their hands before they donned another pair of clean and/or sterile gloves. She stated that for any process from clean to dirty tasks, the staff were to remove the dirty gloves, perform hand hygiene, and don clean gloves. During an interview on 04/04/2026 at 1:00 PM, the Administrator stated that staff had been trained and were expected to remove gloves, perform hand hygiene, and don clean gloves when completing tracheostomy care. 2. An admission Record revealed the facility admitted R9 on 06/24/2024. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of pressure a Stage IV pressure ulcer of other site. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/11/2026, revealed R9 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. The MDS indicated that the resident had two Stage IV pressure ulcers. Review of R9's Care Plan Report included a focus area initiated 08/05/2024 and revised 11/24/2026, that indicated the resident had pressure ulcers including on their right lateral lower leg. Interventions directed staff to administer treatment as ordered (initiated 08/05/2024). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R9's Order Summary Report, with active orders as of 04/03/2026, revealed an order, dated 03/30/2026, for wound care to the right lateral leg. The order specified to cleanse the wound, pat dry, apply a skin barrier, cover the wound with a gauze dressing impregnated with petrolatum followed by calcium alginate, wrap with gauze, cover with a bandage, and apply an elastic tubular support [NAME] for compression. The order indicated that the wound care was to be completed daily and as needed. During and observation of R9's wound care on 04/01/2026 at 9:43 AM, Licensed Practical Nurse (LPN)4 performed hand hygiene, donned a clean pair of gloves, removed a dirty dressing from the resident's right ankle, discarded the dressing, then, wearing the same gloves, cleaned the right ankle wound with wound cleanser. LPN4 discarded one glove during the procedure and donned another clean glove without performing hand hygiene prior to donning a new glove. During an interview on 04/01/2026 at 10:12 AM, LPN 4 stated that she was required to sanitize her hands between glove changes. She stated that prior to going from a dirty procedure to clean procedures, she was to discard her gloves, wash her hands, then put on clean gloves. During an interview on 04/04/2026 at 12:35 PM, the Director of Nursing (DON) stated that staff were required to wash their hands before they donned another pair of clean and/or sterile gloves. She stated that for moving from a clean to dirty task, the staff were to remove their dirty gloves, perform hand hygiene, and don clean gloves. During an interview on 04/04/2026 at 1:00 PM, the Administrator stated that staff had been trained and were expected to remove their gloves, perform hand hygiene, and done clean gloves providing wound care.3. A facility policy titled, Isolation - Categories of Transmission-Based Precautions, revised 09/2022, revealed, Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. The policy further revealed, Contact Precautions included, 1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment; 7. Staff and visitors wear gloves (clean, non-sterile when entering the room; and 8. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid potentially contaminated surfaces with clothing after gown is removed. An admission Record revealed the facility admitted R87 on 03/23/2026. According to the admission Review, the resident had a medical history that included but was not limited to diagnoses of an infection following a procedure, other surgical site. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/30/2026, revealed that R87 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. The MDS indicated that the resident had a wound infection. Review of R87's Care Plan Report revealed a focus area initiated 04/01/2026, that indicated that resident was on isolation precautions due to MRSA infection. Interventions initiated 04/01/2026 directed staff to follow universal precautions when working with residents in isolation; maintain isolation with contact precautions; perform hand washing after completing care and leaving the room; and use personal protective equipment (PPE) as recommended for the type of infection. Review of R87's hospital Infectious Disease Progress Note, dated 03/16/2026, revealed that the resident developed wound tunneling after surgery on 11/21/2025 with increased drainage from a right lateral knee wound on 01/05/2026. The record revealed that cultures from the wound had Methicillin-resistant Staphylococcus aureus (MRSA; a type of staph infection). The record revealed surgical cultures on 01/09/2026 revealed Bacteroides fragilis (B. fragilis; an anaerobic, Gram-negative bacterium), MRSA, and klebsiella pneumonia (extended spectrum beta lactamase [ESBL] positive, which is a bacteria that makes it resistant to many antibiotics). The record indicated that surgical cultures on the right femur tissue on 02/24/2026 grew MRSA. Review of R87's Order Recap [Recapitulation] Summary contained an order, dated 03/23/2026, for the resident to be on contact precautions related to MRSA. The order also indicated that provision of all care and therapy was to be provided in the resident's room every shift until 04/07/2026. The Order (continued on next page)

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	425314	A. Building B. Wing	04/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Recap Summary contained an order, dated 03/23/2026, for linezolid (an antibiotic) oral tablet 600 milligrams (mg), one tablet by mouth every 12 hours for MRSA until 04/07/2026. The Order Recap Summary also contained an order, dated 03/23/2026, for vancomycin hydrochloride (HCl) (an antibiotic) oral capsule, 125 mg, one capsule by mouth twice a day for a history of Clostridioides difficile (C-diff; a bacterium causing severe, watery diarrhea, abdominal pain, and colitis often following antibiotic use) until 04/07/2026. Review of R87's Progress Notes included an Admission/re-admission Summary Note, dated 03/23/2026 at 6:14 PM, that revealed that the resident arrived via stretcher after a hospital stay for open reduction internal fixation (ORIF) of the right hip and a wound infection. The note indicated that Resident #87 was on contact precautions for MRSA in the wound until 04/07/2026. During an interview on 03/31/2026 at 2:44 PM, R87 stated they were on isolation for C-diff and MRSA. An observation on 04/01/2026 at 12:28 PM during the noon meal service revealed that R87 had a plastic cart outside their room for PPE. Certified Nurse Assistant (CNA) #19 entered the resident's room to take a meal tray to the resident and did not apply any PPE before entering the room.ˆ During an interview on 04/01/2026 at 2:43 PM, CNA19 stated that R87 was on contact precautions. She stated that staff were supposed to use hand sanitizer before entering the room and apply all the PPE before going into the room.ˆShe stated that she thought she did put PPE on. CNA19 stated that staff had to set up the resident's tray. She stated that at their last meeting for infection prevention, staff were told to apply gloves and hand sanitizer when going in and coming out, and to remove the PPE when coming out of the room. During an interview on 04/01/2026 at 2:49 PM, CNA17 stated that before going into the room, staff should get all their supplies, apply a gown, gloves, and a mask, then wash their hands or use hand sanitizer. CNA17 stated that when coming out of the room, staff should remove the gown and then wash their hands. CNA17 stated that staff should put a gown on when going in to take a tray into the roomˆbut did not think so if they were not touching anything. During an observation on 04/02/2026 at 12:31 PM, CNA7 took R87's meal tray into their room but did not put on any PPE. After setting up the resident's tray on the over-the-bed table, she exited the room without completing hand hygiene. During an interview on 04/02/2026 at 12:39 PM, CNA7 stated for contact precautions, staff should wear a gown, mask, and gloves. She stated that she did not know if she had to wear full PPE when she took the resident's meal tray in. She stated, I just asked because I wasn't sure. and was told no. She stated that she asked another CNA. During an interview on 04/02/2026 at 12:45 PM, Licensed Practical Nurse (LPN)1 stated that staff should wear a gown and gloves whenever entering a resident's room who was on contact precautions.ˆIn regard to when staff delivered meal trays, she stated that they should wear a gown and gloves.ˆ During an interview on 04/03/2026 at 2:29 PM, the Director of Staff Development (DSD), who was also the Infection Preventionist, stated that staff should be wearing gloves and gowns when passing meal trays.ˆ During an interview onˆ04/04/2026 at 10:48 AM, the Assistant Director of Nursing (ADON) stated that staff should wear a gown and gloves when delivering meal trays to residents on contact precautions. During an interview on 04/04/2026 at 12:05 PM, the Administrator stated he heard about the issue with the contact isolation room. He stated that he expected staff to follow all of contact isolation requirements and to wear the appropriate PPE. 4. A facility policy titled, Legionella Water Management Program, revised 09/2022, revealed, Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. The Policy Interpretation and Implementation revealed, 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. The policy revealed, 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. The policy revealed, 5. The water management program includes the following elements, which included, b. A detailed description and diagram of the water system in the facility; c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria; d. The identification of situations that can lead to Legionella growth; e. Specific measures (continued on next page)

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	425314	A. Building B. Wing	04/04/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	used to control the introduction and/or spread of Legionella; f. The control limits or parameters that are acceptable and that are monitored; g. A diagram of where control measures are applied; h. A system to monitor control limits and effectiveness of control measures; i. A plan for when control limits are not met and/or control measures are not effective; and j. Documentation of the program. The policy continued, 6. The water management program is reviewed at least once a year. Review of a binder containing an undated Legionella Control Toolkit, developed by the United States Department of Health and Human Services (DHHS), Centers for Disease Control and Prevention (CDC), provided by the facility staff as their water management plan, revealed the first page of the binder was a document that included a building water description that listed out where the water entered the main line of the facility and how that water traveled through the facility; indicated having a back flow device at the road; and that once water entered the building, it supplied the kitchen, laundry, resident rooms, showers, ice machine, beauty shop, housekeeping closets, and nourishment kitchens. The document also indicated that there were seven water heaters in the facility. The document revealed that it did not include any further information about how the facility monitored the water supply, did not specify any specific measures used to control the introduction of situations that could lead to Legionella growth, a diagram of where control measures were applied, a system to monitor control limits and effectiveness of control measures, a plan for when control limits were not met or not effective, or any evidence of when the plan was reviewed. During an interview on 04/03/2026 at 12:59 PM, the Maintenance Director stated he had worked at the facility for about two and a half years. In regard to the water management program, the Maintenance Director stated that he may check ice makers, but the facility's water was from the city, so they did their testing for any water-borne illness. He stated that he did not monitor any of the water in the facility unless something was brought to his attention. Per the Maintenance Director, for things like shower heads, other than cleaning them, they only replaced them if they got nasty but stated that they usually were broken and replaced before they got to that point. The Maintenance Director stated that the diagram in his binder only showed the water going into the water heaters. He stated that they had one eyewash station in the kitchen. He stated that he checked the ice makers randomly to make sure they were clean, but he did not have anything in writing to show where he was monitoring or what points within the facility could be considered a potential risk for development of waterborne illness. He stated that he did have a cleaner that he poured down the drains but understood that there should be more to the water management program. During an interview on 04/03/2026 at 2:29 PM, the Director of Staff Development (DSD), who was also the Infection Preventionist, stated they had not had any residents who had tested positive for Legionnaire's disease. She stated that she was not involved at all with the water management plan.ˆShe stated that she helped the Maintenance Director make sure the water was working if needed but nothing else with the water management program.ˆ During an interview on 04/04/2026 at 11:34 AM, the Director of Nursing (DON)ˆstated that she expected that the water management program to be monitored by maintenance staff, who should be doing it according to the policy. She stated that the policy should include how they monitored water sources to ensure there was no stagnant water and no risk of waterborne illness. She stated that she was not aware of any outbreaks of waterborne illnesses at the facility. During an interview on 04/04/2026 at 12:05 PM, the Administrator stated that he did not know a lot about the water management plan. He stated that he thought the water should be tested annually, and there should be something in the diagram of what the points of concern were and how those areas were being monitored.ˆ

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	425314	A. Building B. Wing	04/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, and facility policy review, the facility failed to maintain a medication error rate of 5 percent (%) or less. There were 6 errors out of 44 opportunities, which resulted in a medication error rate of 13.64% for 3 (Residents (R)22, (R)14, and (R)62) of 3 residents observed for medication administration. Findings included: Review of a facility policy titled, Administering Medications, revised 04/2019, indicated, 4. Medications are administered in accordance with prescriber orders, including any required time frame. 1. An admission Record indicated the facility admitted R22 on 03/23/2026. According to the admission Record, the resident had a medical history that included but was not limited to a diagnosis of gastro-esophageal reflux disease without esophagitis. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/30/2026, revealed R22 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. Review of R22's Order Summary Report, with active orders as of 04/01/2026, revealed an order dated 03/23/2026, for famotidine oral tablet 20 milligrams (mg), with instructions to give one tablet by mouth one time a day for acid reflux. During an observation of medication administration on 04/01/2026 at 8:07 AM, Licensed Practical Nurse (LPN)2 administered medication to R22, including one famotidine 10 mg tablet. During an interview on 04/01/2026 at 12:38 PM, LPN2 stated that the resident should have had two pills (for a total of famotidine 20 mg) administered based on the physician orders and based on the medication that she had on hand. She stated she had been trained and was expected to follow the physician's orders for medication administration. During an interview on 04/04/2026 at 12:35 PM, the Director of Nursing (DON) stated that the resident should have been given two tablets (for a total of famotidine 20 mg) instead of one tablet (famotidine 10 mg). She stated that staff had been trained and expected to follow physician orders. During an interview on 04/04/20206 at 1:00 PM, the Administrator stated that staff had been trained and expected to follow physician orders regarding medication administration. 2. An admission Record indicated the facility admitted R14 on 03/17/2026. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of muscle weakness and hyperlipidemia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/24/2026, revealed R14 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident had severe cognitive impairment. Review of R14's Order Summary Report, with active orders as of 04/01/2026, revealed an order dated 03/17/2026 for ferrous sulfate oral tablet delayed release 324 milligrams (mg), with instructions to give one tablet by mouth one time a day every Monday, Wednesday, Friday for anemia. The Order Summary Report revealed an order dated 03/17/2026 for fish oil oral capsule 1200 mg, with instructions to give one capsule by mouth one time a day for heart disease. During an observation of medication administration on 04/01/2026 at 8:20 AM, Licensed Practical Nurse (LPN)1 administered medication to R14, including one ferrous sulfate oral tablet delayed release 325 mg tablet and fish oil oral capsule 500 mg, two capsules by mouth. During an interview on 04/01/2026 at 12:26 PM, LPN1 stated that the ferrous sulfate order for R14 was not what the facility had in stock. She stated the order should have been for ferrous sulfate 325 mg instead, and the dose she administered was 325 mg. LPN1 stated the facility did not carry fish oil 1200 mg and the order was changed after she spoke to the Nurse Practitioner (NP) to fish oil 500 mg two tablets to start on 04/02/2026. She stated that based on the previous orders, she administered the medications incorrectly. She stated she had been trained and was expected to follow the physician's orders for medication administration. During an interview on 04/03/2026 at 10:29 AM, the NP stated that she would have reviewed the resident's medications and signed off on them after staff inputted the information in the system. She stated that the fish oil 1200 mg should have been given and not fish oil 1000 mg that the resident received and was an oversight. She stated the ferrous sulfate dosage could have been an oversight as well because the house stock for the facility was ferrous sulfate 325 mg. 3. An admission Record indicated the facility admitted R62 on 12/24/2025. (continued on next page)

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	425314	A. Building B. Wing	04/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of muscle weakness and infection and chronic obstructive pulmonary disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/27/2026, revealed R62 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. Review of R62's Order Summary Report, with active orders as of 04/01/2026, revealed an order dated 03/09/2026 for fluticasone propionate suspension 50 micrograms (mcg), with instructions to give one spray in each nostril every morning and at bedtime for allergic rhinitis. During an observation of medication administration on 04/01/2026 at 8:30 AM, Licensed Practical Nurse (LPN)3 administered medication to R62, including saline nasal spray 0.65%, one spray to each nostril. During an interview on 04/01/2026 at 12:45 PM, LPN3 stated that she spoke with central supply about the saline nasal spray and was told that she should have used fluticasone propionate suspension spray and the two medications were not the same. She stated she had been trained and was expected to follow the physician's orders for medication administration. During an interview on 04/02/2026 at 4:46 PM, the Medical Director stated that the nurse should have checked with the Nurse Practitioner (NP) and the resident before saline nasal spray was administered to see if the resident desired to take it. During an interview on 04/04/2026 at 12:35 PM, the Director of Nursing (DON) stated that the expectation for the nurse would have been to notify the physician that the fluticasone propionate suspension spray was not available and documentation placed in the resident's progress notes.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, facility policy review, and review of manufacturer guidelines, the facility failed to follow a physician's order to remove a lidocaine patch for 1 (Resident (R)62) of 3 residents observed for medication administration. Findings included: Review of a facility policy titled, Administering Medications, revised 04/2019, indicated, 4. Medications are administered in accordance with prescriber orders, including any required time frame. Review of Manufacturer guidelines titled, Lidoderm, dated 01/2015, revealed, Apply Lidoderm to intact skin to cover the most painful area. Apply the prescribed number of patches (maximum of 3), only once for up to 12 hours within a 24-hour period. Review of R62's admission Record revealed the facility admitted R62 on 12/24/2025. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of infection and inflammatory reaction due to indwelling urethral catheter and muscle weakness. Review of R62's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/27/2026, revealed R62 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. The MDS indicated R62 received a scheduled pain medication regimen. Review of R62's Order Summary Report, with active orders as of 04/01/2026, revealed an order dated 01/26/2026 for lidocaine external patch 5%, with instructions to apply to affected area topically one time a day for pain and remove per schedule. Review of R62's Medication Administration Record [MAR] for 03/2026, revealed a transcription of a physician order dated 01/27/2026 to apply a lidocaine external patch 5% to the resident's affected area topically one time a day for pain and remove per schedule with instructions to apply the lidocaine patch at 9:00 AM and remove the lidocaine patch at 8:59 PM. Per the MAR, Licensed Practical Nurse (LPN)5 initialed the resident's MAR to indicate she removed the resident's lidocaine patch on 03/31/2026 at 8:59 PM. During an observation of medication administration on 04/01/2026 at 8:48 AM, LPN3 obtained a lidocaine external patch 5% for administration to R62's sacrum. R62 had a lidocaine patch on their sacrum dated 03/31/2026. LPN3 removed the lidocaine patch dated 03/31/2026 and applied a new lidocaine patch 5% dated 04/01/2026 to the resident's sacrum. During an interview on 04/01/2026 at 3:40 PM, LPN3 stated she removed a lidocaine patch from R62's sacrum prior to applying a new lidocaine patch. LPN3 stated that the lidocaine patch she removed from the resident's sacrum should have been removed during the night shift per the physician's order (on 03/31/2026). During an interview on 04/02/2026 at 12:41 PM, LPN5 stated she could not remember if R62 had a lidocaine patch on or if she had removed the patch. She stated that when she worked, she would remove the patch. LPN5 stated that the resident would request that the patch remain on until the next morning. LPN5 stated she was expected to remove the lidocaine patch as ordered by the physician. LPN5 stated the lidocaine patch was to be placed on the resident by the day shift staff and removed by the night shift staff. During an interview on 04/02/2026 at 5:00 PM, the Medical Director stated that he was unaware of any adverse reactions for a lidocaine patch staying on a resident longer than the ordered prescription but would expect staff to follow the physician's order for use. During an interview on 04/03/2026 at 3:24 PM, the Consulting Pharmacist stated that the manufacturer's guidelines stated that lidocaine patches were to be removed from a resident after twelve hours. He stated the manufacturer's guidelines for usage stated for the patch to only be used twelve hours within a 24-hour period. The Consulting Pharmacist stated the expectation was that staff followed the physicians' order for usage. During an interview on 04/04/2026 at 12:35 PM, the Director of Nursing (DON) stated staff were trained and expected to remove patches as ordered by the physician. During an interview on 04/04/2026 at 1:00 PM, the Administrator stated staff were trained and expected to follow physician orders as it related to medication administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425314	A. Building B. Wing	04/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Post-Acute	109 Bentz Road Piedmont, SC 29673

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure sufficient bowel monitoring for 1 (Resident (R)26) of 1 sampled resident reviewed for bowel monitoring. Findings included: A facility policy titled, Bowel Management Protocol, dated 02/15/2015, revealed, It is the policy of this facility to ensure that residents are free from complications secondary to constipation. This will be accomplished through adequate assessment, tracking and treatment as indicated. The policy also indicated, Normal bowel pattern is once every day up to once every three (3) days. Constipation results from factors such as immobility, decreased activity, and as a side effect of numerous medications. The policy also indicated, CNAs [certified nursing assistants] to document each shift the number of bowel movements and size of bowel movements on the resident flow record. The policy also indicated, The Unit Manager will review the resident flow record daily and compose a list of those residents having not had a BM [bowel movement] in three (3) days. The policy also indicated, The nurse will provide medication as ordered by the physician or obtain a physician's order, to residents on the bowel care list. The medication given should be recorded on the MAR [Medication Administration Record]. The policy also indicated, The nurse is to follow up on those residents and document results. The nurse will document results in the chart and on the MAR just as would be done for any PRN [as needed] medication. Documentation should include size and consistency of the bowel movement. (Documentation should match the resident flow record that the CNAs complete). A facility policy titled, Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol, effective 09/2017, revealed in the section Monitoring and Follow-Up that, The staff and physician will monitor the individual's response to interventions and overall progress; for example, overall degree of comfort or distress, frequency and consistency of bowel movements, and the frequency, severity, and duration of abdominal pain, etc. [et cetera, and other similar things].^ A facility policy titled, Change in a Resident's Condition or Status, revised 02/2021, revealed, Our facility promptly notifies the resident his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g. [exempli gratia, for example] changes in level of care, billing/payments, resident rights, etc.). An admission Record revealed the facility admitted R26 on 04/25/2019 and readmitted the resident on 06/19/2025. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of constipation, major depressive disorder, and cognitive communication deficit. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2025, revealed R26 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The MDS indicated R26 required substantial to maximum assistance with toileting. The MDS indicated the resident was always incontinent of bowel. A significant change MDS with an ARD date of 01/13/2026, revealed R26 had a BIMS score of 4 out of 15, which indicated the resident had severe cognitive impairment. The MDS indicated R26 required substantial to maximum assistance with toileting. The MDS indicated the resident was always incontinent of bowel. The MDS indicated R26 was on hospice services. Review of R26's Care Plan Report included a focus area, initiated on 07/06/2025 and revised on 03/13/2026, that indicated the resident was at risk for gastrointestinal problems related to constipation and gastroesophageal reflux disease (GERD). Interventions directed staff to: Administer medication per the physician's order, monitor the effects, and notify the physician if problems were not relieved; Monitor and document bowel movements every shift; and Monitor for signs and symptoms of gastrointestinal problems and report abnormal findings to the physician. Review of R26's Order Summary Report, with active orders as of 04/01/2026, included: - GlycoLax Powder (Polyethylene Glycol [PEG] 3350, a laxative solution) 17 grams by mouth in the morning for constipation. Hold for loose stool (in Liquid). Mix with 4 - 8 ounces of liquid, started 06/25/2025; - Sennosides Tablet 8.6 milligrams (mg) two tablets by mouth two times a day for constipation, started 06/24/2025; and - Side effects monitoring for (continued on next page)

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	425314	A. Building B. Wing	04/04/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Anti-Depressant medication every shift including monitoring for constipation, started 06/19/2025. Review of a facility document titled, [Vendor Name] Standing Orders, dated 07/01/2024, revealed, These orders are standard prn orders designed to streamline care delivery and eliminate lag times in patient care. The document indicated, Constipation: Colace [a stool softener] 100 mg po [by mouth] two times per day prn constipation Or MOM [Milk of Magnesia, a laxative] 30 cc [cubic centimeters] po daily prn constipation. Review of R26's Medication Administration Record (MAR) dated 03/2026, revealed Colace and MOM were not administered. Review of R26's Documentation Survey Report, dated 03/2026, revealed the resident had no bowel movements documented from 03/12/2026 to the day shift of 03/19/2026 and from 03/20/2026 through 03/31/2026. Review of R26's Task: Bowel Continence record dated from 03/04/2026 through 04/04/2026, revealed the resident did not have a bowel movement documented from 03/12/2026 through 03/19/2026 and from 03/21/2026 through 04/01/2026. The Task Bowel Continence record revealed: on 03/20/2026, the bowel movement consistency was Soft; on 04/02/2026 at 3:51 PM, the bowel movement consistency was Constipated/hard; and on 04/02/2026 at 11:27 PM, the bowel movement consistency was Loose/Diarrhea. Review of a facility document titled, Nurse Communication Log, dated 03/14/2026 through 04/02/2026 and located in the Doctor's Book at the nurses' station, revealed R26 was not listed with a concern. Review of a facility document titled, Clinical and Order Alerts Listing Report, dated from 03/12/2026 through 03/19/2026, revealed R26 was not listed on the report. Review of a facility document titled, Clinical and Order Alerts Listing Report, dated from 03/21/2026 through 04/02/2026, revealed R26 was not listed on the report. Review of R26's hospice Visit Note Report, dated 03/30/2026, revealed the resident had a bowel movement on 03/28/2026 and had normal bowel sounds in all four quadrants. Review of R26's hospice Facility Visit Log, dated 04/02/2026 at 10:20 AM, revealed, ? constipation. Added Dulcolax supp [a laxative suppository]. Review of a nurse's Progress Note[s], dated 04/02/2026 at 11:56 AM, revealed, N.O. [new order] to start Dulcolax Rectal Suppository 10 MG (Bisacodyl) Insert 1 suppository rectally one time only for Constipation until 04/02/2026 12:00 AND Insert 1 suppository rectally one time a day for constipation. Review of R26's hospice Facility Visit Log, dated 04/02/2026, revealed, Patient complained of gas pains and was washed up [cleaned]. During a phone interview on 04/01/2026 at 10:52 PM, Licensed Practical Nurse (LPN)9 stated CNAs charted bowel movements, and she did not know if the nurses were supposed to be checking it. LPN9 stated she was sure the bowel movements were checked daily, but she was not sure how that worked. LPN9 stated that by the third day, or probably the second day, if a resident had not had a bowel movement. they should give the resident something. LPN9 stated if a resident went three days without a bowel movement they would give the resident a suppository. LPN9 stated no one had told her a resident had not had a bowel movement. LPN9 stated if a resident did not have a bowel movement for three days, she would notify the provider, there might be a standing order she would follow, and, if not, she would call the provider. LPN9 stated no one told her that R26 had not had a bowel movement. During an interview on 04/02/2026 at 11:11 AM, Hospice Registered Nurse (HRN) stated the hospice visits for R26 were scheduled weekly and as needed. HRN stated a family member called hospice and requested hospice go see R26 and that was why he was at the facility that day. The HRN revealed that R26 might be a little constipated. The HRN stated constipation was part of the pain the resident was having, so they ordered suppositories. During an interview on 04/02/2026 at 3:06 PM, LPN8/Supervisor stated that nurses were to check the electronic medical record system for a resident's bowel schedule. LPN8 stated a resident should have a bowel movement in three days. LPN8 stated she made a list of residents who had not had a bowel movement for a few days and let the nurses know that those residents needed their PRN medications. LPN8 stated the computer system kept the running list, and she printed it off. LPN8 stated she looked at that list daily, but she did not keep copies of the list. LPN8 stated she did not document when she notified a nurse to provide the PRN medications for bowel movements. LPN8 stated that she looked at the list that week and the week prior. LPN8 stated she thought R26 was on the list for last week on Friday (continued on next page)

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	425314	A. Building B. Wing	04/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(03/27/2026) and also on Monday (03/30/2026). LPN8 stated she asked R26's nurse to give the resident MOM. LPN8 stated the nurses should look at the bowel list, but she thought the nurses relied on her to let them know if a resident had not had a bowel movement in three days. LPN8 stated if a CNA told a nurse that a resident did not have a bowel movement in three days the nurse should follow up, and if a resident did not have an order for MOM they should get one, administer the MOM, and complete a nurse's note. LPN8 stated constipation was an ongoing thing for R26. LPN8 stated R26 would get a little constipated and then have a bowel movement. LPN8 stated that without nurses' notes she could not say if the resident refused the additional treatment for constipation. LPN8 stated, after she reviewed R26's MAR and bowel movement Task Report, that the nurses should have notified her so that R26 could have been put on the bowel movement Alert List. LPN8 stated the hospice aides should report bowel movements to them. LPN8 stated that information should be passed on from shift to shift, and it would be documented in the CNA documentation. During an interview on 04/02/2026 at 3:31 PM, CNA7 stated residents' bowel movements were documented in the electronic medical record. CNA7 stated if the resident had more than one bowel movement on a shift, they would document it each time. CNA7 stated that usually the hospice aide would tell them if a resident had had a bowel movement. CNA7 stated she worked with R26 from 03/20/2026 through 04/01/2026, and R26 did not have a bowel movement during her shifts. CNA7 stated if there was an issue with a resident not having a bowel movement she would report it to the nurse. During a follow-up observation and interview on 04/02/2026 at 3:40 PM, R26 stated they just had a bowel movement after a suppository, the bowel movement was as hard as a rock, and that was why their bottom was hurting. R26 stated it had been two weeks since their last bowel movement, staff had been giving them something for the constipation, but it had not worked, and that was why the bowel movement was as hard as a rock. R26 stated that now they had a bowel movement, they felt better. R26 stated the nurses had kept checking on them, and the resident told the nurses the resident was fine. During a follow-up interview on 04/02/2026 at 3:48 PM, CNA7 confirmed she took care of R26 on her shift on 03/14/2026, 03/15/2026, 03/18/2026, 03/19/2026, 03/22/2026, 03/23/2026, 03/27/2026, 03/28/2026, 03/30/2026, 04/01/2026, and 04/02/2026. CNA 7 revealed R26 did not have a bowel movement during CNA7's shifts from 7:00 AM to 7:00 PM. During an interview on 04/02/2026 at 3:50 PM, LPN2 stated she did not know R26 was having a bowel movement issue until the hospice nurse came and told her that day. LPN2 stated she was PRN and that the CNAs charted bowel movements. LPN2 stated CNAs would usually tell the nurses if a resident had not had a bowel movement in a while. LPN2 stated the CNAs should alert the nurse. LPN2 stated she did not look at the bowel movement Task Report. LPN2 stated she was not sure who monitored the bowel movements. LPN2 stated she was not notified at all about R26 not having a bowel movement until that day.ˆ During an interview on 04/02/2026 at 4:16 PM, LPN8 stated there were no nurses' notes related to bowel movements for R26 during the time period of 03/12/2026 through 03/19/2026 and from 03/21/2026 through 04/01/2026. LPN8 stated R26 did not appear on the clinic report, which showed bowel movement alerts, for the time periodˆof 03/12/2026 through 03/19/2026 and from 03/21/2026 through 04/01/2026. LPN8 stated the clinic report was the same report as the Alert Listing. LPN8 stated that R26 did not appear on the Alert Listing. LPN8 stated if a resident did not have a bowel movement in three days the resident should be on the Alert Listing. During a phone interview on 04/02/2026 at 8:55 PM, LPN10 stated she relied on the CNAs to tell her if a resident did not have a bowel movement. She stated if a resident did not have a bowel movement in two to three days the CNA should tell her. LPN10 stated CNAs documented bowel movements in their charting system, and normally if a resident had not had a bowel movement in a while the CNAs usually said something. During an interview on 04/03/2026 at 8:37 AM, the Assistant Director of Nursing (ADON) stated LPN8 generated bowel movement monitoring reports for the whole building, and if a resident did not have a bowel movement for three days it would be flagged in the system on the dashboard. The ADON stated nurses monitored bowel movements shift to shift. The ADON stated CNAs could go into the charting and see the resident's bowel movement history for (continued on next page)

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	425314	A. Building B. Wing	04/04/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	three shifts prior to their shift, but CNAs were not expected to do that. During an interview on 04/03/2026 9:01 AM, LPN3 stated the CNAs let nurses know when a resident had a bowel movement or if it had been a few days since a resident had a bowel movement. LPN3 stated they could monitor bowel movements on their computer, and they were alerted by the unit manager when a resident had not had a bowel movement in three days. During a phone interview on 04/03/2026 at 10:19 AM, the Nurse Practitioner (NP) stated no one notified her about lack of bowel movements for R26 from 03/12/2026 to 03/19/2026 or from 03/21/2026 to 04/01/2026. The NP stated if a resident had not had a bowel movement within five days the staff should contact her and going beyond five days that would start to be concerning. The NP stated there were standing orders available if a patient had complaints of constipation or hard stool or if CNAs noted the resident did not have a bowel movement in three days and the nurse noticed the resident did not have a bowel movement in three days. During a follow-up phone interview on 04/03/2026 at 10:58 AM, LPN6 stated she was not notified of R26 not having a bowel movement, and the CNAs would notify her or the nurse. LPN6 stated the CNAs monitored the bowel movements. She stated R26 was able to tell the nurse if the resident was in pain or constipated, and the resident had not voiced to her that the resident was constipated. LPN6 stated that for monitoring of bowel movements she would ask CNAs, and most of them communicated very well with the nurses. LPN6 stated she could go into the CNAs' portal to see bowel movements, but it was mostly communicated by the CNAs. During a phone interview on 04/03/2026 at 11:34 AM, LPN11 stated the CNAs monitored the bowel movements, and they let the nurses know if they needed to look or if there was a concern. During an interview on 04/03/2026 at 2:43 PM, CNA17 stated they documented bowel movements on the chart, and she monitored bowel movements by keeping track of whether or not a resident had a bowel movement. CNA17 stated if they did not have the same resident every day they would not know about the resident's bowel movements. CNA17 stated she would probably notify the nurse if a resident did not have a bowel movement in two days. During a follow-up interview on 04/03/2026 at 4:10 PM, the ADON stated she was not made aware of R26 not having a bowel movement for two weeks. During a phone interview on 04/03/2026 at 4:37 PM, the Medical Director stated if a resident did not have a bowel movement from 03/12/2026 to 03/18/2026, that it was a very long time not to have a bowel movement. The Medical Director stated it was hard to believe a resident did not have a bowel movement from 03/21/2026 through 04/01/2026. The Medical Director stated that unfortunately constipation came with the territory with a hospice patient. The Medical Director stated that it sounded like something could have been looked at a little more closely for the lack of bowel movements. The Medical Director stated that it was a clinical issue, was something staff needed to be aware of, and brought to the nurses' and providers' attention. The Medical Director stated that it was disturbing that someone may have gone a two-week period without a bowel movement and no one knew about it. The Medical Director stated that he did not know how that would slip through the cracks, and it should not happen, not being recognized and addressed. During an interview on 04/03/2026 at 4:57 PM, the ADON stated if hospice services had communicated with them that R28 had a bowel movement they would have put it into their system. The ADON stated that from her understanding hospice services did not communicate that R26 had a bowel movement on 03/28/2026. The ADON stated facility staff depended on the Alert Report, and the Director of Staff Development (DSD) monitored CNA documentation. The ADON stated LPN8 monitored the reports, pulled the report daily, and told the nurses if a resident did not have a bowel movement. The ADON stated her expectation was the CNAs were to communicate if they saw a resident was constipated or a resident verbalized they were constipated. The ADON stated that ultimately the nurses were responsible to monitor bowel movements using the dashboard along with their audits. During an interview on 04/04/2026 at 8:38 AM,ˆLPN12 stated she was the weekend supervisor. LPN12 stated for bowel movement monitoring staff knew their residents, and LPN8 ran the bowel movement report during the week, and she (LPN12) ran it on the weekends. LPN12 stated she did not recall R26 being on the bowel movement Alert Listing. LPN12 stated the CNAs were good (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about telling the nurses about residents' bowel movements. LPN12 stated at the end of the day it was the nurses' responsibility to make sure the residents were having bowel movements.ˆLPN12 stated there were hospice books at the nurses' station, and when hospice came in they would ask hospice what was going on with a resident and the last time the resident had a bowel movement. LPN12 stated if it had been over three days since the resident's last bowel movement and a resident did not have an order or PRN order they had standing orders they could use. LPN12 stated R26 usually had a bowel movement every day to every other day. LPN12 stated she did not know about R26 not having a bowel movement between 03/12/2026 through 03/19/2026 or from 03/21/2026 through 04/01/2026. LPN12 stated she should have been alertedˆby a CNA, the resident, or the electronic medical record system. LPN12 stated CNAs were the first line, and there was an alert on the computer screen that would show up if a resident did not have a bowel movement in 72 hours. LPN12 stated an alert about R26's bowel movements did not show on the screen that she recalled, and the resident was never on the bowel movement report. LPN12 stated R26's cognition had declined and the resident would report they had not had a bowel movement when they actually had one. During an interview on 04/04/2026 at 12:19 PM, the Director of Nursing (DON) stated her expectation was that the unit manager ran the report from the electronic medical record daily of resident's who had not had a bowel movement, and, if it had been three days they acted on the protocol based on what the doctor prescribed and made sure the resident had a bowel movement and documented it. The DON stated the nurses should always check the CNA documentation to ensure it was completed and to check the bowel movements. The DON stated the CNAs should be documenting in real time, and if it was noticed that it had been two or three days since a resident had a bowel movement to let the nurse know. The DON stated CNAs could look into the charting where bowel movements were documented and should be able to see previous days of charting. The DON stated everything should be documented. During an interview on 04/04/2026 at 12:43 PM, the Administrator stated his expectation was that if a resident did not have a bowel movement in the required timeframe staff was to make sure the resident was taken care of. The Administrator stated they should have a system in place to monitor bowel movements, and when there was an issue it was pushed to the proper people to address it.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on facility policy review, record review, observation, and interview, the facility failed to ensure staff provided catheter care appropriately for 1 (Resident (R)69) of 1 resident reviewed for catheter care.Findings included: Review of a facility policy titled, Catheter Care, Urinary, revised 09/2014 revealed, The purpose of this procedure is to prevent catheter-associated urinary tract infections. The policy revealed, Steps in the Procedure included, 13. With nondominant hand separate the labia of the female resident or retract the foreskin of the uncircumcised male resident. Maintain the position of this hand throughout the procedure; 14. Assess the urethral meatus; and 15. For a female resident: Use a washcloth with warm water and soap to cleanse the labia. Use one area of the washcloth for each downward, cleansing stroke. Change the position of the washcloth with each downward stroke. Next, change the position of the washcloth and cleanse around the urethral meatus. Do not allow the washcloth to drag on the resident's skin or bed linen. With a clean washcloth, rinse with warm water using the above technique. Review of R69's admission Record revealed the facility admitted R69 on 05/11/2017. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of neuromuscular dysfunction of bladder and muscle weakness. Review of R69's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/24/2026, revealed R69 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. The MDS indicated the resident had an indwelling catheter. Review of R69's Care Plan Report included a focus area initiated on 10/01/2025, that indicated the resident was at risk for complications with their urinary system related to having an indwelling catheter. Interventions directed staff to provide catheter care and empty the catheter every shift and as needed (initiated on 10/01/2025). Review of R69's Order Summary Report, with active orders as of 04/03/2026, revealed an order, dated 07/24/2025, for indwelling urinary catheter care to be provided every shift and as needed. During an observation of R69's catheter care on 04/03/2026 at 11:00 AM, Certified Nursing Assistant (CNA)22 obtained all the supplies for catheter care, performed hand hygiene, and donned personal protective equipment (PPE). CNA22 obtained warm water, liquid soap, and a clean washcloth and exposed the resident for care. During catheter care, CNA22 cleaned the foley catheter from the outside of the labia to the area of the foley catheter attached to the resident's leg. CNA22 failed to separate the labia and cleanse the urethral meatus. During an interview on 04/03/2026 at 11:20 AM, CNA22 stated she thought that she had cleansed the resident's meatus but remembered that she had not. During an interview on 04/04/2026 at 1:00 PM, the Administrator stated that staff were expected to follow the facility's policy and procedures for catheter care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425314	A. Building B. Wing	04/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Post-Acute	109 Bentz Road Piedmont, SC 29673

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, record review, and facility policy review, the facility failed to ensure a resident's medical record accurately reflected the removal of a lidocaine patch ordered by the physician for 1 (Resident (R)62) of 3 residents observed for medication administration. Findings included: Review of a facility policy titled, Charting and Documentation, revised 07/2017, revealed, 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. An admission Record revealed the facility admitted R62 on 12/24/2025. According to the admission Record, the resident had a medical history that included but was not limited to a diagnosis of muscle weakness. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/27/2026, revealed R62 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. The MDS indicated R62 received a scheduled pain medication regimen. Review of R62's Order Summary Report, with active orders as of 04/01/2026, revealed an order dated 01/26/2026, for lidocaine external patch 5%, with instructions to apply to affected area topically one time a day for pain and remove per schedule. Review of R62's Medication Administration Record [MAR] for 03/2026, revealed the transcription of a physician order dated 01/27/2026 to apply a lidocaine external patch 5% to the resident's affected area topically one time a day for pain and remove per schedule with instructions to apply the lidocaine patch at 9:00 AM and remove the lidocaine patch at 8:59 PM. Per the MAR, Licensed Practical Nurse (LPN)5 initialed the resident's MAR to indicate she removed the resident's lidocaine patch on 03/31/2026 at 8:59 PM. During an observation of medication administration on 04/01/2026 at 8:48 AM, LPN3 obtained a lidocaine external patch 5% for administration to R62's sacrum. R62 had a lidocaine patch on their sacrum dated 03/31/2026. LPN3 removed the lidocaine patch dated 03/31/2026 and applied a new lidocaine patch 5% dated 04/01/2026 to the resident's sacrum. During an interview on 04/01/2026 at 3:40 PM, LPN3 stated she removed a lidocaine patch (during medication administration on 04/01/2026 at 8:48 AM) from R62's sacrum prior to applying a new lidocaine patch. LPN3 stated that the lidocaine patch she removed from the resident's sacrum should have been removed during the night shift per the physician's order (on 03/31/2026). During an interview on 04/02/2026 at 5:15 PM, LPN5 stated she could not remember if R62 had a lidocaine patch on or if she had removed the patch. She stated that when she worked, she would remove the patch. LPN5 stated she was expected to remove the lidocaine patch as ordered by the physician. LPN5 stated the lidocaine patch was to be placed on the resident by the day shift staff and removed by the night shift staff.